PSYCHIATRY AND INTERNATIONAL UNDERSTANDING[1]

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Any appraisal of the present status of psychiatry in the realm of international relations might well include the fact that this widening of our professional interest is a very recent development in the history of our Association. It is to be noted, for example, that it was first stimulated by Dr. George H. Stevenson in his Presidential Address in 1941 when he proposed the establishment of a Committee on International Relationships. The Committee was appointed by his successor, Dr. James K. Hall, during the following year and submitted its first report in 1943. It is therefore a tribute to the energetic work and thoughtful planning of Dr. George H. Stevenson, the Chairman of our present Committee on International Relationships, that we devote this afternoon to a Symposium on the Social Sciences and International Understanding. Much of what Dr. Stevenson said in his Presidential Address regarding the psychological factors that bring about wars is equally valid today.

If we consider the progress that psychiatry has made during the past few years in the field of international relations we see that it is very considerable and that it represents a wholesome addition to our customary preoccupations with clinical problems. When we inquire into the *nature* of what we have learned about international relations, we must admit that our accomplishments have more to do with the development of our interest and our widening sense of responsibility toward these larger human problems and less with any new psychological discoveries or additions to scientific knowledge. Much of what we have learned about international relations during the recent years was in fact already known to at least some of our colleagues in other countries or to those social scientists who had been studying these problems before our interest in them was aroused by such leaders as Dr. George H. Stevenson, Dr. Brock Chisholm, and Dr. John R. Rees.

The first contribution of psychiatry to international understanding has been the establishment of lines of communication between psychiatrists working in many different countries. The first International Congress on Mental Hygiene in 1930 was a historic moment in that it brought together some 3,000 persons representing 50 nations besides the United States. The American Association for the Study of the Feeble-Minded and the American Psychoanalytic Association prepared the programs of their annual meetings in close cooperation with the Program Committee of the Congress in order that the four programs might complement each other and on the whole represent a completeness not otherwise obtainable. This first international meeting of psychiatrists and representatives of related disciplines was the first great meeting of minds in the application of mental health principles to education, to industry, to the family, and to the life of the community. One session of this Congress was devoted to a world view of mental hygiene, and one speaker on the entire program of the Congress discussed mental hygiene and world health. This meeting marked the beginning of international understanding in the field of mental health. One of its formal aims was to consider ways and means of world cooperation and of more effective promotion of mental hygiene in the various countries. The lines of communication established by this first Congress were perhaps rather transitory and they were secondary and incidental to the meeting itself. A great many psychiatrists from many different countries became acquainted with each other, exchanged ideas, and learned from one another. The historical importance of this great Congress cannot be overlooked.

It would seem to me that the second contribution of psychiatry to international understanding has been connected with the interdisciplinary or multiprofessional method

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of studying various universal problems in the field of mental health. In this connection, Dr. H. C. Rumke of Utrecht, Holland, made the following comments as recently as last year:

> Scientifically trained psychiatrists will agree that, as Jackson puts it, psychiatry studies the life of men under a certain specific condition of life; that is, disease; or as Henri Ey remarks, the morbid conditions which deprive man of his inner freedom. The realization of this opens the way to the study of man as such, and just as it is impossible for the neurologist to do any important work without the collaboration of the physicist and the chemist, so, in such a study, the psychiatrist cannot achieve a high professional standard without the help of the neurologist and his team, without the psychologist, without the educationalist, and the sociologist. For such a psychiatrist it is clear that in the realm of mental health—which is not identical with that of psychiatry, nor is a mental health worker necessarily a psychiatrist—progress can only be made by multiprofessional team work.

The pattern for multiprofessional team work has been in existence in the United States for the past quarter century in our child guidance clinics, in which psychiatrists, clinical psychologists, and psychiatric social workers have studied and treated both parents and children coming to these clinics for help. The contribution of psychiatry to multiprofessional work was greatly augmented when in 1947 a large number of psychiatrists participated in the work of the Preparatory Commissions for the Third International Congress on Mental Health. Out of these experiences has developed the realization of a need for research into the workings of such multiprofessional groups. In this connection, it is to be noted that the UNESCO Conference on World Tensions, which was an international multidisciplined group meeting in Paris in 1948, made the following statements:

> Many social scientists are studying these problems, but social scientists are still separated by national, ideological, and class differences. These differences have made it difficult for social scientists to resist effectively the emergence of pseudo-scientific theories which have been exploited for their own ends.
>
> Objectivity in the social sciences is impossible to achieve whenever economic or political forces induce the investigator to accept narrow and partisan views. There is urgent need for a concentrated, adequately financed international research and educational programme.

The International Preparatory Commission functioning in connection with the Third International Congress on Mental Health stated, "Team work between those trained in medical, social, and psychological sciences is urgently needed for certain kinds of study. In practice this has been found difficult. An attempt should be made to discover from experiments so far undertaken what methods have been favorable or unfavorable to success." I would remind you again that our efforts at international understanding are extremely recent in origin; that it was not until 1947 that psychiatrists joined hands with workers from the social sciences in studying basic international problems of mental health; that it was not until 1948 that psychiatrists and social scientists from various parts of the world established a continuing organization known as the World Federation for Mental Health. Although this organizaton, in which psychiatrists are assuming major responsibilities, is but in its infancy, its progress is most gratifying. Unlike the meeting in 1930, the Third International Congress for Mental Health, through its International Preparatory Commission, made numerous recommendations concerning general education, the education of specialists, the education of the general public and research. It also made specific recommendations of an international character to the United Nations and to the World Health Organization.

In other words, psychiatry has made a definite effort to make available any information it has at its disposal to various agencies that deal with problems of international cooperation and understanding. The problem that naturally arises in the mind of every psychiatrist is, first, whether the rôle of the psychiatrist is that of developing a special professional skill by means of which he would promote international understanding or whether his task is to broaden and deepen the understanding of human behavior so that the social scientist and the practical political worker might use this new knowledge in the service of international understanding. As Dr. Lasswell will tell you, international understanding is not a simple matter but a complex system of attitudes enabling us to attain peaceful settlements of

difficulties that arise between peoples and groups of nations. Such a system of attitudes is extremely complex and depends upon a great number of factors. As psychiatrists we know, of course, that the emotional, psychological factors are among the most potent ones but as psychiatrists we must train our eye on realities. And therefore it is incumbent upon us not to overlook the fact that economic, social, and religious conditions are either heavily charged with emotions or they arouse most intense and frequently unreasonable emotions among those of us who under ordinary conditions are normal and reasonable. The question then arises: what control has the psychiatrist over those economic, social, and religious factors, the understanding of which is extremely important but which in themselves becloud man's understanding of his own relationships to his fellow man? This question the psychiatrist is unable to answer. It is the practical social scientist, it is the scientific sociologist, it is the cultural anthropologist who must take over the task of pondering the ever-increasing mass of psychological data that the psychiatrist offers. My position might be misunderstood and it might be taken as an attempt on my part to relieve the psychiatrist of his social responsibilities. I do not intend to relieve the psychiatrist from any of his responsibilities, social or moral, but it must be clear that the psychiatrist is not a practical sociologist and is not a magician who by virtue of his knowledge of the psychology of men could be considered as holding the key to world understanding. That is the reason why a gathering like this in which psychiatrists like myself, social scientists, anthropologists, and historians must get together in order to work out the methods, which are as yet to be found, and the ways and means, which are yet to be discovered, for working together to achieve the goal of helping the job of international understanding. Psychiatry alone cannot do it. Sociology alone has proved its inability to do it through 130 odd years of its existence, and cultural anthropology alone certainly cannot do it. Therefore, when I accepted the invitation of Dr. Stevenson to open this session with a talk on psychiatry and international understanding, I felt that my own personal views as a citizen and my own personal social philosophy should remain personal and set aside in favor of those to whom social problems are a matter of daily professional concern like the gentlemen who are to follow me. What was left for me then was to state briefly and humbly that psychiatry is ready to do all that it can; but that the most that it is able to do it can do only in close cooperation with all other social disciplines: with this particular emphasis, that these social disciplines take full cognizance of what psychiatry has to offer about the mind, the emotions, and the behavior of men in action whether normal or abnormal.

THE SCIENTIFIC STUDY OF BIPOLAR ATTITUDES [1]

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For purposes of this paper the term "international understanding" designates a system of attitudes in support of peaceful settlement of difficulties among nations. The term is not limited to declarations in favor of peace. A system of peace-supporting attitudes must also sustain procedures by which difficulties, once arisen, can be disposed of by methods short of war, and by which altercations can be prevented from arising in the first place.

We are, of course, interested in the general theory of international understanding, but our chief concern is with factors in the present world picture. These are the elements that we must be able to control if policies of international understanding are to succeed. By now it is obvious that international understanding in our day is deeply conditioned by the bipolar structure of world politics. At the moment the globe is not formally partitioned between the Soviet Union and the United States, and yet it is becoming plainer year by year that the affairs of every lesser power must be carried on with an eye to the two giant powers. Powers that do not become satellites of the U.S.S.R. turn for military, economic, diplomatic, and ideological assistance to the U.S.A. The bipolarizing process is slowly consolidating the peoples of the globe in two garrisoned camps engaged in an arms race devising weapons of unprecedented destructiveness.

We look to specialists of many kinds for help in analyzing the principal factors with a bearing upon international understanding. Historians describe the development of the dominant institutions of every power now active in world politics. Historians also describe the interaction of powers who have long since vanished from the globe, but whose relationships resemble some conspicuous feature of the present. Social scientists (political scientists, economists, sociologists, anthropologists, social psychologists, social geographers, for instance) make two contributions: first, systematic tools for analyzing the social process; second, observational procedures for direct description of the process. In the following pages I refer to some of the principal features of the current world situation, and comment upon available knowledge relating to them. (For convenience alone the propositions are numbered.)

1. The present difficulties of world politics reflect a state of global anarchy.

This is the quickest way to sum up the present state of affairs: The existing structure of world government is too weak to arouse and sustain the expectation that it is capable of saving the peace. The United Nations, as is well known, breaks down if the two giant powers cannot act together in a crisis.[3]

2. We cannot rely upon the expectation that a new war will be waged by weapons of unprecedented destructiveness to ensure the success of international understanding.

It was often suggested during the nineteenth century that war by modern weapons is too horrible to contemplate. But this did not prevent war. And today we have a firmer grasp of some of the factors that render such a response unlikely. We know, for example, that aggressors are always able to count upon the human factors, and to cherish the hope that they can knock out the enemy's capacity to resist by sabotaging his installations and undermining his ideological unity (4-11). You and I may decry this as suicidal from the point of view of the whole of mankind. But our disapproval does not abolish the likelihood that some ruling groups will gamble on the human factor in preference to the voluntary relinquishing of power. We must also remember that our scientists and engineers cannot *guarantee* the annihilation of the globe.[4] They can only predict that

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[3] Current texts and treatises on world politics emphasize this fundamental factor. See references 1-3.

[4] The views of scientists who are willing to speak for publication are found in the *Bulletin of Atomic Scientists*, Chicago. See also references 12, 13.

under certain circumstances this can happen. Since some of these conditions are the human factors which it is the stock in trade of politicians to manipulate, we see why we cannot obtain peace through anticipatory horror.

3. We cannot rely upon mass yearning for a peaceful life to bring about international understanding.

There is not much doubt that honest polls of general opinion in Nazi Germany would have shown that most of the population wanted to stay at peace rather than to fight. This is so even when we make allowance for the youngsters who were indoctrinated with the neolithic heroism of the Führer.[5] But the renunciation of war, even in other countries, is rarely absolute. If "our" community is attacked by any "other," the inhabitants of most communities rally to resist external dictation. When refusal to fight is not absolute, the news is open to manipulation to show that the occasion has arisen when fighting is necessary.

The opportunity to test reality has now been effectively denied to most of the people of the globe.[6] The rulers of totalitarian Russia, for example, exercise a stringent monopoly over the means of communication. The effect is not only to blind the Russian people to the world outside, but to blind the people of other countries, the United States included, to the facts about Russia. Americans can no longer rely upon our usual methods of testing reality, since there is no longer a stream of self-correcting statements emanating from correspondents, students, scholars, business men, and tourists who traverse the length and breadth of Russia.

Common sense and science alike tell us what happens when uncertainty is not corrected by reality, but when deep anxieties are aroused. The "curtains" of contemporary world politics weaken the reality-testing processes of the ego, and evoke fantasies projected from the inner caves of human personality. Fantastic hostilities and equally fantastic affections fill in the blanks left by inadequate neighborly contact.

4. The present world situation is complicated by the fact that one of the giant poles of international politics is totalitarian, and that a totalitarian state has the advantage over a more popular state in secrecy and surprise.

It is obvious that the freedom of action of despotisms and dictatorships is far greater than the freedom of leaders who are more immediately responsible to the people. The rulers of Soviet Russia could stagger their own people by concluding a pact with Hitler in 1939. The rulers of Japan could plan and execute Pearl Harbor prior to a declaration of war.

There are some qualifications that need to be made about the advantages of dictatorship and despotism. All such régimes are not efficient. When Turkey was the "sick man of Europe" it was not too difficult to learn of the plans of the government, owing to the corruption and slackness then prevailing.[7]

We should not overlook the success of nontotalitarian and parliamentary régimes in keeping secrets vital to their security. The British government saved itself from destruction by many measures, not the least of which was a new and secret technology for detecting aircraft.

Such considerations do not reassure us at present since there are no reliable signs of creeping corruption and inefficiency inside Russia. In examining the total situation, however, we cannot ignore the problem of determining the circumstances in which tendencies of this kind will emerge.

5. The psychological structure of totalitarian systems makes for war.

We know that the top elite in totalitarian dictatorships is in perpetual fear of assassination and revolt, and that the faintest breath of criticism is interpreted as a symptom of present or potential defiance, and is therefore punished. Hence aggressive impulses throughout the ruling hierarchy tend to be directed outward against "others" and down-

[5] A. V. Dickes, M. D., of London has made the most exhaustive analysis of the correlation of political attitudes in Germany with the structure of German society. This was done during the war and will soon be published. The standard review of psychological and other factors relating to war is by Quincy Wright(14).

[6] Concerning restrictions upon the free flow in information see reference 15.

[7] For an informative volume on espionage in diplomatic history see reference 16.

ward to those occupying a humbler position in the pyramid. Love is supposed to be directed upward to the person, party, and principle of the ruling order. But the context of menace is so great that love is mixed with fear, and the result is worshipful awe. Love of colleagues and subordinates is conditional, conditional upon loyalty to the régime. It is, of course, realistic to fear denunciation for disloyalty. But apprehensions are also fed from all the inner stresses that arise in the task of imposing a strict conscience whose sole imperative is "Obey." The isolation of every ego from the ego of every other individual is counteracted by orgiastic ceremonials that permit renewed and enhanced identifications with the régime, and the total relinquishing of detailed conscience-direction to commands emanating from "above."

Given such a psychological structure the "war scare" is both a technique of manipulation that is available to the rulers in order to divert hostilities abroad, and a spontaneously generated occasion for the discharge of unbearable anxiety, and for revalidating the whole system by which individuality is sacrificed to the régime.

Potent as the psychic factors are, we must avoid exaggerating them into a diagnosis of "inevitable" war. Not all hierarchical régimes have retained whatever expansive vigor they had at the beginning. More light is needed on such questions as these: Under what circumstances are the intelligence sources that are relied upon by the dictatorship inclined to exaggerate the degree of internal disaffection and weakness? To exaggerate unity and strength? Under what conditions do the intelligence sources either magnify or minimize the disunity and weakness of foreign powers, especially democracies?[8]

6. Continuing crisis favors the universalizing of garrison-prison state systems.

In some ways this is the most ominous feature of the world situation in which we live, since it implies a gradual weakening of factors that operate in favor of wider understanding. One of the best established propositions in social sciences is that institutions centralize in response to recognized external threat(20). The application to the present situation is this: If the present crisis of national insecurity continues, the institutions of nontotalitarian countries will take on more totalitarian traits.

Tracing this process in more detail, the following rough sequence would be anticipated in a country with our social structure: As more national income is devoted to armament and other forms of national security expenditure, the influence of the federal government rises in relation to state and local government. As barriers are imposed upon sources of information at home and abroad, public opinion becomes less informed and effective in influencing government. Political parties decline, and parliamentary institutions decline. The civilian elements in the executive and administrative arms of government decline in relation to the armed services. The one exception is the agency (or agencies) performing the political police function, which grows in weight since, in the general atmosphere of suspiciousness, loyalty inquiries are made not only of government employees, but of all who receive contracts or aid from the government for production, research, or study. Managers, workers, scientists, engineers, and students come under increasing surveillance. If the crisis continues for several years, all the institutions of freedom are likely to suffer as power becomes concentrated in fewer hands. These hands are likely to be specialists on violence (army, navy, air, police), and especially those who specialize on providing the information on which determinations of loyalty are based.

Developments in the direction of a garrison state (or a garrison-prison state) are counteracted by the vigor with which free institutions are protected and the skill with which they are adapted to the requirements of perpetual crisis. Once more, it is useful to warn against translating some special feature of the situation into a forecast of "inevitability." We remember that important leaders of opinion told us in 1939, 1940, and 1941 that if the United States participated in World War II it would be impossible for free institutions to survive. These prophecies were false, since they under-

[8] An appraisal of German intelligence services during World War II is given by Milton Shulman. (17). Concerning U. S. Intelligence problems see references 18, 19.

estimated the resilience of the institutions of civil liberty, freedom of enterprise, and civilian supremacy in the texture of American civilization.

However, if the crisis endures for several years, may there not be danger of attrition, danger that the conception of freedom will itself change through long-protracted adaptation? Obviously, we need more light upon the effect of crisis upon the institutions of liberty, such as can come by more careful study of the historical situations in which external menaces of many years' duration were lived through(21-23).

7. The expectation of "inevitable" war and victory does not make war in fact inevitable.

The doctrine of the Russian elite holds that capitalistic states are bound to experience recurring crises of unemployment and that the ruling class in America, for instance, will encircle and attack Russia as a means of diverting the hatred of the unemployed masses against an external target. This is part of the doctrine that world revolutionary communism will eventually triumph everywhere.

There is no doubt that dogmatic expectations of war and victory must be numbered among the factors making for war rather than international understanding. But the study of past cases reminds us that a myth of inevitable victory is not always to be taken at face value. The prophecies of world conquest made by followers of Mohammed survived long after the Mohammedan states had entered into diplomatic, trading, and cultural relations with the infidel. The doctrine declined to the status of an incantation uttered on ceremonial occasions. What happened was that power was met with power, which set a term upon the expansion of Islam by the sword. Hence, the readjustment of the intensity and immediacy of application given to the dogma of inevitable victory by conquest.

The application to the present situation appears to be that if Russian power is counteracted by non-Russian power and a stalemate develops among the two great garrisons, the dogma of world revolutionary success may undergo a similar process of redefinition. From time to time, Stalin has already given support to the thesis of the possible "coexistence" of socialism and capitalism. Although specialists on Russia often interpret this as a tactical move on Stalin's part to lull the West into a false sense of security, the appearance of this doctrine of "coexistence" paves the way for the revision of the thesis of inevitability if Soviet expansion is firmly blocked(24).

8. Economic instability works against international understanding unless compensated against by special policies, such as the maintenance of income, and shared enlightenment about the working of the economy.

It is generally recognized in the United States that prolonged mass unemployment is politically dangerous, since it creates mass disaffection that may be turned to the advantage of Russia. In common with all other Western industrial states, the United States has been modifying its social institutions for the purpose of preventing or cushioning shocks arising from economic instability. The essential point is to provide quick compensations against loss of income. Most social security measures are arrangements for income maintenance. Policies for the support of farm prices, the underwriting of bank deposits, and provision for emergency public works are examples of measures that have the same stabilizing purpose and effect. To the extent that these policies succeed in reducing the sense of economic and social insecurity, they reduce the incentive to imagine or discover either saints or devils outside the frontier.[9]

9. Bipolarity does not make war "inevitable."

I return for one closing remark about the bipolar structure of world politics. The visible preoccupation of the world with the danger of war has given plausibility to the suggestion that a bipolarized world is "inherently" unstable, a prelude to a struggle for world mastery culminating in a universal state.

Now there have been universal states in the past, if we define the expression to mean that all peoples in significant contact with one another have been gathered under the

[9] On the degree of flexibility in the various economic patterns now prevailing in the world, see references 25-27.

same roof. At times China has been the site of a universal state in this sense.

We must, however, be on guard against schemes that talk in terms of "inevitable" sequences. It is true that two great centers of power have fought it out for mastery. But it is also true that the issue has sometimes been indecisive, and that the structure of effective power has moved toward a pluripolar rather than a unipolar form(28-34).

10. The implication of what has been said for policies of international understanding: Many lines of action are useful, though none can be considered a panacea.

The foregoing enumeration of factors at work in the current world situation is far from complete, but it points to one great implication for policy that I should like to underline. If international understanding is our goal value, it depends upon a complex context, a dynamic equilibrium of many factors operating on a global scale. The present bipolar and semitotalitarian structure of world politics puts severe limits upon many lines of policy. Many useful initiatives can be taken, nevertheless, for the purpose of preventing the present situation from exploding into war.

The United States, for example, can maintain sufficient armed strength to deter an aggressor from operating against the United States or any part of the globe outside Russia that we regard as essential to our security. Strategic measures of this scope call for economic, diplomatic, and ideological policies capable of unifying the non-Russian world into a strong free world commonwealth. If such policies are to succeed abroad, they must be accompanied by appropriate measures at home. The United States must maintain high levels of productive employment, proceed with the liquidation of social discrimination, and make no unnecessary sacrifices of individual freedom during the continuing crisis of national security.

Despite the ominous menaces in the present world situation, it is not a foregone conclusion that the present crisis will terminate in general war, rather than in an eventual resumption of peaceful cooperation on a broadening scale. But the inventory of factors at work suggests that we will make more steps toward a garrisoned and bipolar world before we come to a halt and start moving directly toward a world community in which international understanding is the norm in both theory and fact.[10]

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ON METHODS OF THE SOCIAL SCIENCES IN THEIR APPROACH TO INTERNATIONAL PROBLEMS [1]

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Science is no reality outside human minds. Individuals are our realities; they are the units of the social sciences. But the sciences again depend upon individuals and the most successful methods invented by Man, the scientific methods, are not perfect. The individual's mental handling of his experiences is imperfect. He compares, differentiates, and groups them together. He describes such group concepts to himself in images, together with images of expected recurrences of similar happenings or their symbols, and conveys such concepts to others by means of language. His group concepts not only suffer from the imperfections of his observations, but they are under the constant inspiring or falsifying influence of his emotions. He is inclined to consider his images as representing realities, and even words may become substitute images for providing "conditioned reflexes."

Science is in reality individual, but we are trying to achieve greater and greater certainty that others see things as we do and understand environments, events, and natural "laws" that we have established, in the same way as we do. We seek thus from others consent to our insight and, when we get it, we strengthen our faith that we have found scientific truth about objective reality.

Science tells us that war no longer serves, biologically, the survival of the best. Victory goes more and more to those who happen to have within their territory the few top brains that invent the best means of destruction. We have not the remotest guarantee that a next World War will bring victory to those with the best political, social, or economic system, quite apart from the fact that the destruction in a third World War would approach suicide of homo sapiens. Scientists are therefore interested in preventing war and promoting the organization of peace.

Science can be applied to the problems of cooperation, both by promoting cooperativeness and by eliminating hostility and aggressiveness. That is in particular the promise of psychiatry and similar sciences.

In applying science, mental groupings, pure concepts, and human observations and assertions about realities must never be confounded with reality. Here is a danger point in the social sciences.

Group psychology is thus a misnomer, for only the individuals with their mentations and emotions are realities, but the individuals think, feel, and act differently when grouping themselves, or identifying themselves with a "group" concept. The explanation may have to be found in caveman psychology, but the fact is undoubted. "Group therapy" is not a therapy of a group. What happens is that so many individuals, when induced to work out their own salvation through "sharing" of thoughts and emotions, react differently from what they would do isolated or in a doctor's consultation room.

In the "identification" taking place at school, in the army, or less strongly in group therapy, identification is really not with a group, but with a group concept, and that concept is in individuals and nowhere else, different in each one, and, at its best, very similar in all of them. And as a group is not a reality, it cannot identify with individuals, which are the only realities. Psychiatrists are not healing a group, but individuals, and probably in various degrees.

Mary P. Follett said, "We do not live in the Community, the Community lives in us." This is the truth in a nutshell. And I venture to suggest that the full realization of this fact may act as a strong catalyst in the social sciences. For therein is concentrated their possibilities of practical application. One may examine and condition or decondition individuals, but communities are hope-

[1] Read at the 106th annual meeting of The American Psychiatric Association, Detroit, Mich., May 1-5, 1950.

[2] Envoy Extraordinary and Minister Plenipotentiary, Permanent Delegate of Denmark to the United Nations.

less as objects for science, as they lead us only into philosophy and ideologies.

We must face the fact that we can define by philosophical methods, but not describe by natural science methods: "State," "Country," "People," "Nation," "Government," or any other "institution" or "group." They are not realities. If this goes against the grain, we are not well related to reality, but are suffering from a severe attack of "stereotypitis," and had better see a psychiatrist and—more humiliating—a semanticist.

I do not for one moment deny that, in order to live together and preserve the possibility of our living together in our time, we have to inject the emotion of patriotism into what we call the "personality" of children and adolescents, and keep such emotion warm in adults. But from a scientific point of view "nation" is no reality, and the earlier this be recognized by all the social sciences, the better.

And unfortunately the anthropomorphizing or the personalizing of the basic concepts of state, nation, country, people (which are results not of a biological, but of a historical development), blurs the whole picture of things as they are. The propagandist makes people believe that these concepts are realities, and often the leaders themselves do not know what they really are. Full understanding of the fact that these concepts are not realities, but that the individuals who handle these concepts on our behalf are the realities, will in what is called "international life" increase the responsibility where it ought to be increased, in the life of the significant individuals, the policy-making leaders.[8]

Let us then turn from science to the world of statesmen, politicians, and diplomats. These men and women generally believe themselves very realistic in spite of all their failures—for wars, unemployment, and the like, are their failures—and they consider the scientists—"with all respect"—as theorists. But the truth is that the policy-making leaders are living in a realm of theoretical and philosophical concepts. For their basic concepts are government, state, country, people, nation, institutions, economic and social forces, and these concepts are generally held in the form of stereotypes with strong emotional strings attached. And the leaders are pulling on the strings of the others, the men in the street, and doing it more and more with a semiscientific knowledge of human nature.

Now, the way things are going, the common man wants somebody to complain about, and he seems to have chosen the politician. He is criticizing him severely from many points of view. Allow me therefore to say that my experience through many years of international conferences has convinced me that policy-making leaders generally are above the average man in intelligence, that most of them want sincerely to find the right solutions to public problems, that they know full well their shortcomings in regard to knowledge and are anxious to get all possible applicable, scientific knowledge. Of course, there are among them—as among all of us—some men and women of warped personality, who may even be psychopaths, individuals who are suffering from insufficiency of love during childhood, or who have a strong desire for power because they have not been able to integrate.

It appears as if the progress of physical hygiene, which has increased health and the life span of individuals so much during the last 50 years, will now be followed by a similar development in psychiatry and its kindred sciences. To me there opens a vision of resulting release from frustration, saner realism introduced in all of us children and adults alike, fertility of unhampered and straight thinking, and human energy that will offer mankind possibilities far beyond the promises of atomic energy.

If we consider health—as do the World Health Organization and the World Federation for Mental Health—not simply as absence of disease, but as optimum unfolding of the individual, I think we can agree that we common men are all suffering from underdevelopment, frustration, and other emotional disturbances. We are now content if our minuses do not necessitate institutionalizing, and if we can live together with others without too much friction. The mature mind is rare.

[8] The term "policy-making leader" is used for any individual leading in the planning of policy or in carrying out a planned policy.

But our group concepts have hindered us in seeing that, while it is highly desirable that all children be developed on mental health lines, so as to become more cooperative and understanding than we were educated to be, and while it is equally important to heal the common adult, nevertheless a war may be brought about, even unwittingly, by those significant individuals who are sitting on the nerve centers of developments, *viz.*, the policy-making leaders. Two billion ordinary human beings are far ahead of their governments in a desire for peace, but the historical situation is that their actions are emotional reactions to the stereotypes, and the leaders are not only themselves working in the midst of these same stereotypes, but are tied to those of the electors for getting elected, or for keeping in power.

The social sciences will then have to examine what leaders are positively dangerous, and help to eliminate them.

If war, as has been said, is too dangerous a problem to leave in the hands of generals, the maintenance of peace is too fragile to be left in the hands of politicians and diplomats. The destereotyping of them may almost be accomplished intellectually, though we will meet resistance in the form of superiority, irony, and irritation.

Psychiatrists would much prefer to have them as patients. Well, I do not think I can promise many clients, though the time may come that no one will or dare present himself as candidate for election to Parliament without having a Certificate of Mental Health. It has at any rate been a great satisfaction to read out of case histories that disinhibiting actors or authors does not deprive them of their abilities; on the contrary it removes hindrances from their work. There is no reason to believe that it would be different in the case of policy-making leaders.

William C. Menninger, in his *Psychiatry in a Troubled World,* points out that the personnel policy of taking only the best qualified is unnecessarily harsh on the handicapped and might reasonably be modified so as to ask if the handicap really interferes with the performance of the handicapped. As we have not enough qualified people to go round, that viewpoint may well apply to some of the policy-making leaders, for instance in diplomacy; on the other hand it may be found that misassignment in diplomacy is causing disabling stress.

Within reach psychiatrists will find certain consequences of the realistic viewpoint. In countries where elections are free, the social scientist may not merely influence the many individual voters, but he may shortcut by centering his effort on the individual candidate. Dr. George H. Stevenson, in 1943, called attention to the question of leadership from a psychiatric point of view. All power to psychiatry in such studies and in the application of results.

Again I urge the individual approach: more value may be obtained from intimate conversation with one good observer, or one leader willing to speak, or one obstinate resister, than by academic studies on leadership and followership. And by getting more value from such an approach I mean: getting more insight, getting more influence, and getting more ideas of research possibilities. Of course I attach top interest to the *influence* that psychiatrists may exercise for the maintenance of peace, and I expect much of psychiatry then, for in spite of my admitted ignorance of psychiatric science, I can say that I know enough of it to understand that it might contribute very much in practice.

I may further be allowed to stress that the psychiatrist's training is the one that has the deepest individual approach; he is trained in considering the individual patient in his entire complex situation, and the individual policy-making leader must under no circumstances be considered exempt from this approach. His assumptions should be looked into and his motives examined. For instance, why does he give way to pressure groups?

However, there is one fact psychiatrists will have to face: your presentation as psychiatrists to policy-making leaders is often resistance-creating. We do no longer chain the madmen, but we still recognize only physical disease as legitimate, reasonable, honorable. But as psychiatrists are not the only social scientists that have to enter the field of international understanding, they should come in with a team of others, the semanticists, the sociologists, the social psychologists, the anthropologists. Perhaps it may be found practical to organize with them

a special body of social scientists, not too official, not too authoritative, not too representative, nor on a geographical basis, and then approach individual members of Parliaments, of governments, of Foreign Offices, with a view to asking them to help you to find out in what way the social sciences may help them in their work. Then try to induce, on an individual level, your administration to accept your unpretentious offer and request—for it will at the same time be a request for opportunity for research—that experiments be carried out in practice.

Here let me stress the necessity of using scientists of the highest attainments and with wide experience, first, because peace is a serious and urgent problem, and secondly, because the first approach is an experiment. If it is not well done there will be less willingness to continue or repeat. Such highly qualified scientists are needed, thirdly, because their training must have taken place before entering the field, and fourthly, because the real possibilities for true experimenting are next to nothing. It is true that political life unfortunately is experimenting, but rarely if ever can one repeat an experiment; what has been done has altered conditions for the next one. It looks like eternal emergence.

This leads me to re-emphasize that science is fundamentally individual, and has to be lived. This is particularly the case in the situation in which the psychological scientists enter international life. For, while psychiatrists in their profession consider it a condition for success of treatment of the patient that he is willing to cooperate, they will rarely if ever have that situation in international life. But they will then, in order to arrive at maximum usefulness, have to develop a method by which they can deal with the patient, not in order to heal him, but to prevent him from doing mischief; he is dangerous to his surroundings.

It seems at first glance that you would have to concentrate on the United Nations, since it is the Peace Organization. But strangely enough the Charter expressly permits the greatest risks outside the scope of that organization, for the greatest risk is a conflict between Great Powers, and then the veto may exclude action. This was perhaps a necessary element in the Charter in order that the Great Powers would accept the voting of small countries on an equal footing. But the consequence of it is here that the social sciences, and especially psychiatry, must concentrate more on the significant individuals of the Great Powers, and that this cannot be done only at the United Nations' meetings because the most significant individuals may not be in actual attendance.

Allow me here a few words on the understanding of "international understanding." As "nations," scientifically speaking, are not realities, we cannot work with a concept "inter-national" which means "between nations." What we are really trying to demonstrate is that a great many human individuals called nationals of country A have attitudes of mind, emotions, and ideas in regard to "nationals" of countries B, C, D, et cetera and vice versa. You are using the words "International Understanding" in this symposium, because you want to indicate that these individuals do not have enough knowledge of the others, and that they ought to be induced to visualize the situations of the others, their motivations, when known, with a sympathy or empathy leading to attitudes less dangerous to peace and more conducive to cooperation.

Now clearly, we cannot, in abstracts, inform or convince a nonexisting entity, a "nation," and how many of the individuals, the "nationals," can be reached? I submit, and I venture to say that I have seen it confirmed in many situations at Geneva and Lake Success, that the more we think in terms of "nations," "countries," "peoples," the more unrealistic becomes our reasoning, the more we enter the field of emotions thought of as a propaganda field, and the more our resolutions will be deprived of relationship to the realities of the political situation.

"Understanding" has a most dangerous element of imagery. We have images of our own people and of foreign people—they have images of us and of themselves, one image not at all corresponding to the other, for they have no realistic basis at all and have strong emotions securely glued to them. With how many of your own nationality

have you lived long enough to know them intimately? There will still be in this country about 150 million people and another 2 billion foreigners abroad to make mistakes about. To the one who has never seen a foreigner, the enemies of one's country are easily recognizable; they look like those of his own people whom he dislikes, colored with an extract of his own hatred of the worst part of himself. He knows them so little that he is ready to kill them.

This is madness, and the melodramatic situation of the common man is actually that he needs that madness to defend himself and others!

It seems impossible to get past that obstacle by understanding in terms of "peoples" or "nations." The problem is too overwhelming, and the solution will be too slow in fulfillment. But it is possible to produce among the few governing, policy-making leaders so much understanding of the true elements of the problems of maintaining peace that war will no longer be thought of as politically expedient. If we think in terms of individuals, we can go for the significant ones who lack that understanding because their personalities, not their intelligence, bar them from true knowledge and understanding. In other words, we must replace those who must understand, but cannot or will not, by others who can and will. This is something that can be managed if the social sciences, in particular psychiatry, deliberately enter the field.

All too often the so-called mature or realistic statesman is one who is ready to take a responsibility on the basis of "hunches." It cannot be stressed too strongly that world politics can under no circumstances be considered as decided upon by mature and sane men on the basis of real knowledge and realistically acquired evaluation. The world of policy-making leaders is an unreal world, and their methods outdated when compared with the realistic methods of science.

As voting in United Nations may have decisive influence on world politics, let me now say that it is my conviction that the General Assembly and other organs of United Nations, including the Secretariat, have more men and women of the modern outlook than had the League of Nations; they are less formalistic, less diplomatic, more realistic, more scientific. The presence of the United States in United Nations has, I believe, been contributive to this. The difference between the two organizations is not very great, and it is easy to see that by selecting the desirable personalities to serve United Nations the entire organization may be changed. Why is that? The charter will not be changed by changing the persons. No, but again the realities of United Nations are those individuals who are acting out the letter and the spirit of the charter.

For that is the naked scientific truth: an organization or institution is no reality but is better described as the men and women who act out that organization-idea, who are intra-organized according to the purposes and principles of, and rules established for, the organization, and are organization conditioned.

That means as well that, if the representatives of the 60 member States of United Nations are changed, United Nations is changed. But of course only that much. If they are subject to instructions from others at home, a change of these others or of their mentality and outlook will be a condition *sine qua non* for an effective change.

The Secretary General of United Nations and some of his top-ranking officers have shown a remarkable understanding of the contributions the social sciences may make to the work of the organization. But they do not dispose freely of United Nations' budget. The money must be voted by a majority of delegations. Again the appropriate approach will be one to individual members of delegations, in particular, members of the most important delegations.

Observations on the spot are obviously a "must." And no one can prevent psychiatrists from collecting material regarding the policy-making leaders' life stories, their public utterances, nor from sitting in the audience and reading the nonverbal signs to which the President of this conference referred a few days ago. The fact that your President has told the world that such signs mean something may influence the interest of the delegates in psychiatry. You can further interview those who understand your desire to be of assistance and who are willing

to help you with information about the personalities of the situations. You may even hope for an occasional request for your opinion.

But the optimum insight and assistance can be obtained only if you as psychiatrists can get an opportunity to do the work itself. Do not be frightened. There is, of course, knowledge to be acquired, but there is absolutely no knowledge that is difficult to learn. If the Assembly or the Economic and Social Council during a session deal with 40 to 60 items, you may be sure that there is not one single representative who knows all of them well. I humbly suggest that you try, on the basis of individual approach, to induce delegations to accept psychiatrists and other social scientists as representatives, councillors, and advisors. I think you will know how to ingratiate yourselves by the mere weight of your science. I know that there are not nearly enough psychiatrists for the tasks envisaged, but if during such studies and assistance to statesmen and diplomats a few psychiatrists should disappear and reappear in active international service as diplomats, in foreign offices, or in politics, the net result from a peace point of view would be positive.

This brings me to a question that I consider of utmost importance. Years ago I urged that the two greatest "movements" of our time—"United Nations" and "Science"—be brought into closer and closer connection. This means that "United Nations" must be surrounded by scientists. It is not enough that the specialized agencies, or the permanent commissions of the Economic and Social Councils, apply science to world problems that *in the long run* are decisive for peace or war; United Nations must draw upon the sciences in its everyday life, first and foremost the social sciences, and among them in particular, psychology and psychiatry.

Now, the knowledge accumulated in the social sciences and the understanding of its possible value to United Nations must of necessity be greater among the scientists themselves than among policy-making leaders and diplomats. I therefore wonder whether the social scientists might not consider the desirability of creating themselves an organ for the purpose of that relationship. It may have as one of its tasks the gradual increase of understanding on the part of the policy-making leaders. I know that the long-term view is already taken into account, for instance, by the World Federation for Mental Health. But I believe a team of scientists, not exclusively social scientists, having the relationship to concrete situations in view, might serve as a nucleus for a greater organization to which United Nations might contribute in money and material, never giving instructions, for their scientific independence must be safeguarded, but asking questions. The organization of the nucleus should be elastic so as to draw upon the various sciences if and when their knowledge is involved.

Such scientific organ might even assist individual delegates in their "headaches" with United Nations' problems.

This would be one of the means by which we may gradually introduce into the thinking of policy-making leaders more and more scientific knowledge, scientific methods, and scientific mentality, and thus gradually substitute the present, essentially emotional basis for peace by a much better and much more reliable one, the scientific view of peace.

Organization of a working group consisting for instance of a psychiatrist, a social psychologist, an anthropologist, a sociologist, a semanticist, and an expert in social engineering or human relations may be enough to begin with as a team, to expand as found necessary. But it should follow United Nations *all the time,* and comment on discussions, procedures, reports, and resolutions. The mere fact of their existence as possible critics may have a tempering effect in the right direction. For not only will the policy-making leaders find it necessary to face scientific facts, but they may learn to *doubt* that they know all they should know before taking decisions. Can the leaders of the Great Powers really *know* how far all the sciences of destruction have advanced in the other countries?

In thinking of peace two words are sufficient to create anxiety: East and West. If we honestly wish, as I am sure we all do, to maintain peace, it is natural to look for common purposes that all mankind may join

to implement. It is my firm conviction that such purposes can be found in Man's common search for truth and in the fullest application of scientific results with a view to making this world a better place to live in for everybody.

I am also firmly convinced that all scientists are interested in this, not merely the social scientists, for all scientists will be social scientists in such a task. For mankind it would not only be madness to start another war, but it *is* madness to go on as we do now, year in and year out, squandering men, money, and material on its preparation. I therefore venture to submit to the participants in this meeting, not as experts of madness, but as experts of sanity, that the scientists themselves, convinced that their methods are the better ones, might start the organization of science and make it a movement of irresistible force.

And here I am not thinking so much of an organ, an institution (though such a one there would have to be)—for it is easy to agree on a high ideal and propose an institution to promote it—no, I am thinking in terms of realities, the individuals. Merely to agree as to its purpose will not be sufficient for its implementation. The task of organizing science is not a matter of proportional representation, not a matter of having the most prominent social scientists on the Board, not a matter of which social science is historically first, or the most developed, of highest morality or efficiency. It is the matter of outlook and attitudes in the individuals in whom is established a vision of purpose, an integrity of moral urge, fertility of ideas, attitudes of cooperativeness, and understanding of the psychological elements of organization.

Social scientists may well contemplate whether such a task in the long run may not be the greatest contribution they could bring to international understanding and thereby to the progress of Mankind.

THE CONTRIBUTION OF HISTORY TO INTERNATIONAL UNDERSTANDING [1]

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History, whether regarded as an art or a science, is an old subject with an old and well-established method for describing and understanding mankind. Since ancient times, historians have been writing of peoples: their early settlements and migrations; their relations with their neighbors; their cultures and civilizations; and the decay, decline, and fall of their empires, kingdoms, and republics. In short, historians have long been tracing and describing human achievements, and have long been interested in what is called international understanding.

As war has been a principal activity of peoples throughout the centuries, historians from earliest times have concerned themselves with it, whether to recount the exploits of its heroes or to describe the misery and suffering war has occasioned. Nor has the advent of scientific history in recent times lessened the interest of historians in war. To the more distinctly military treatment of the subject there has been added, particularly since 1914, an emphasis on the causes and consequences of conflicts between peoples.

To the psychiatrist, psychologist, and sociologist who have more recently entered the field of international affairs, the historian extends his best wishes. He welcomes the interest of these specialists from other fields of learning in the causes and prevention of international tensions and war, for the historian believes that the serious and sustained interest of professional men, in the social studies and related fields, in the great issues of peace and war, will lead to a better appreciation of what is involved, and should in time contribute significantly to the elimination of war.

This goal will not be reached, however, until a greater measure of understanding exists among the peoples of this earth, and the policies of states are grounded on this understanding. What is meant by "international understanding"? It may refer to the knowledge that peoples of the world possess with respect to one another, involving a familiarity with the history, language, literature, art, economy, culture, and civilization of human beings everywhere. It may refer also to the sympathy that they have for one another, and the regard they show for the particular problems and difficulties of each other.

But there is a third sense in which the expression "international understanding" may be used. It may refer to the measure of comprehension possessed by one people with respect to the aims and intentions, the activities and policies of other peoples, particularly as these find expression at the governmental level. Here it is a matter of evaluating the political and economic objectives of other peoples and the manner in which these affect the international scene. More simply, these different meanings of "international understanding" may be expressed as what people know about each other, how they feel towards each other, and what they apprehend of the motives and goals of each other.

International understanding may be said to have been attained when there are no iron curtains and men are free to travel from one part of the world to another; when there is a free interchange of ideas; when dictatorships and police states no longer exist; and when differences between peoples are amicably settled and international tensions, crisis conditions, and wars no longer occur. Obviously the world is far from such a condition today.

Instead, the problem of international understanding today, in its most immediate and critical aspect, is the problem of war and of how to prevent it. From 1815 to 1914, the pattern of international life was one of a century of peace, interrupted by revolutions, local wars, and international crises.

[1] Read at the 106th annual meeting of The American Psychiatric Association, Detroit, Mich., May 1-5, 1950.

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It came to an end with the First World War. Since World War I, the pattern has been one of local wars and crises, a war of nerves, general and total war, armistice conditions, military occupations, a cold war, and recurring crises. In the present state of the world, with the U.S.S.R. and its satellites in Europe and Asia arrayed against the United States, the British Commonwealth of Nations, and Western Europe, peace depends upon the course of action of the Soviet Union and its dependencies and on the reaction of the Western World to the dynamism of the Eastern. From many indications, World War III may not be far removed.

Under these circumstances it is highly relevant to consider the contributions that the various social studies and related subjects can make to international understanding and in particular to the prevention of war, which is, after all, the purpose of the present symposium. As part of this program, it is pertinent to consider the contribution of history to this undertaking.

The contribution of history to international understanding is to be found in the subject matter of history, in the historical method, and in the historical synthesis. The amount of good historical writing is so great today and the coverage so extensive, that one may read the life story of any people, however remote in time and place, and if one has an adequate command of languages, may acquire a detailed knowledge of many peoples. Through the study of history it is possible to gain an increased knowledge and a better appreciation of the way of life, the habits and customs, and the culture and civilization of other peoples; an essential condition if one people is to get on with another.

If the study of history be sufficiently specialized in character and be directed toward international affairs, it becomes possible to evaluate contemporary happenings and to recognize in them the presence of factors and conditions making for international tensions, crises, and wars. Among the uses of history, that of recognizing the presence of incipient aggressions and other dangers is one of the more important, for then policies may be formulated in time to cope with a developing and critical situation.

From the point of view of the historian, international understanding will not be quickly realized. It will take a long time. Over the years it will be necessary for us to learn to understand each other, and to make the adjustments required for living together on a world-wide basis. This will be a matter of enlightenment, a comprehension of each other's problems, and a mutual willingness to make concessions. Here history can be of direct assistance in furthering international understanding.

In the meantime there is danger that among some peoples expansionism will become increasingly active and that aggressive actions will lead to war, as was the case with the Japanese and the Germans after 1931. Against these possibilities, other peoples must be on guard, and must know when to make concessions and when to stand firm. Here the historical study of international relations offers much assistance in enabling one to recognize the existence of danger spots, sources of conflict, hostile tendencies, and in showing how to analyze the march or drift to war.

In these matters the historical method, with its emphasis on events in a time setting and on causal relationships, is particularly helpful. Without entering upon a discussion of the concept of causality—long a topic of interest to philosophers and historians alike—it may be said that historians in general accept causation in history, especially historians of politics and diplomacy.

The historian of international relations distinguishes between underlying causes and immediate origins. He arranges events in chronological order, and seeks to establish causal connections between them. He views events as part of a trend or a development that he tries to demonstrate and explain. He brings the events with which he is concerned, together with their antecedent causes, into a pattern or synthesis, which he sets forth in a descriptive or a narrative form. The historian is also concerned with the consequences and significance of these events. He grounds his work on materials, primary and secondary, which he handles critically, in accordance with certain principles of criticism and rules of evidence.

This viewing of events in a time perspective, in an effort to discover the direction, intensity, and significance of a movement or trend, and the search for causes and effects are essential features of the historical method. They set off the work of the historian from that of his colleagues in the other social studies.

The historian of today, it is probably correct to say, does not believe that wars are inevitable. He believes that wars have arisen from causes that are ascertainable, and that, generally speaking, they could have been avoided. In his opinion, both World War I and World War II could have been prevented. In the case of the latter, the historian can point to several occasions, prior to 1939, when, by firm action on the part of the French and British, Hitler could have been stopped, as in March 1935, when compulsory military service was reintroduced in Germany, and in March 1936, when German troops occupied the demilitarized Rhineland zone.

Likewise, the historian can point to procedures, different from those employed at the time, by which the same end—that of stopping Hitler—could have been achieved. Unless one side is irretrievably committed to war, and this is not usually the case, a war can be averted. Even where one side was bent on fighting, there was, more than likely, some earlier occasion when a different policy by other states could have prevented the war that later came. Nor is this just a matter of the wisdom that comes with hindsight.

This view, that wars are not inevitable, the historian holds because of his belief that within limits, however narrow they may be, men in positions of responsibility and authority still exercise some measure of choice and make and take decisions, and these determinations may avert as well as bring about a war. However important underlying causes may be, they do not offer by themselves a complete explanation, for the rôle of leadership cannot be excluded, as the literature on the origins of World War I has shown. This is just another way of saying that the historian seeks his explanation of events in underlying causes and immediate origins.

By underlying causes the historian means those factors that affect the action and are to be found in the physical environment, the composition and structure of society, and the ideas and institutions prevailing at the time. They are general in character, and relate to the setting and to trends and movements contemporaneous with the events. As underlying causes for the outbreak of war in August 1914, a historian might list, among others, economic imperialism, nationalism, Pan-Germanism, Pan-Slavism, the South Slav movement, irredentism, militarism, navalism, colonialism, the newspaper press, and the system of alliances and ententes. A comparable list, chosen for its bearing on the outbreak of World War II, might include the failure of collective security, the quest for economic self-sufficiency, national minorities and self-determination, treaty revisionism, propaganda, totalitarianism, Communism, Fascism, Nazism, and regional, nonaggression, and mutual assistance pacts. These are but words and phrases to represent underlying causes. When offered as an explanation they require definition and fullness of treatment.

In addition to underlying causes are the immediate origins. By these are meant the activities of individuals whose thoughts, plans, and actions set in motion the occurrences that end in the *coup d'état,* the uprising, the revolution, the war, or whatever the end may be. In the case of immediate origins, the purposes and plans of leaders play a large part, although the results of any action are frequently not those planned or anticipated.

In tracing immediate origins, the historian employs a narrative of events. Starting with a somewhat earlier date than that marking the beginning of the period in which he is chiefly interested, the historian sketches briefly the important happenings along the way. The choice of this earlier date is determined by his judgment of what it is essential to include for an understanding of the subsequent course of action. This part of the narrative is introductory in character.

The historian then traces in more detail the course of events within the time limits of his main period. For example, an account of the crisis of 1914 might begin with a brief treatment of the period from 1871 to

1914, followed by a detailed account of happenings from the assassination of the Archduke Franz Ferdinand, on June 28, 1914, through the entry of Great Britain into the war, on August 4, 1914. Or, an account of the crisis of 1939 might be preceded by a brief treatment of the period from 1919 to 1939, followed by a close examination of events from the destruction of Czecho-Slovakia in mid-March 1939, through the intervention of Britain and France in the war, on September 3, 1939.

In short, in the historical pattern or synthesis, the historian customarily begins with a statement of underlying causes, and follows this with a brief account, introductory in character, of outstanding events that took place immediately before the opening of the period, and have a direct bearing on it. Then comes a detailed narrative of events. A summation of the action and a consideration of the results and the significance of what took place conclude the work. This pattern or mode of presentation is applicable whether the events have to do with a crisis of major importance, or with the immediate past of some current situation that calls for clarification today.

It is here with this pattern for organizing and presenting some segment of the past that history makes a further contribution to international understanding. The historian, more than any other social scientist, is interested in as inclusive a synthesis of causes as possible, and the historical framework readily lends itself to the inclusion of the findings of the psychiatrist, psychologist, sociologist, anthropologist, economist, political geographer, and political scientist, in the field of international affairs.

The historian long has presented a picture of the past, and has supplied data and interpretations to scholars in the humanities and social studies. Now specialists in these fields have an opportunity to repay this debt by furnishing the historian with significant data and interpretations from their research. With specialists from so many fields now active in the study of international affairs, it becomes imperative that the results of their investigations be brought within the limits of a common synthesis. Not only is the historical synthesis admirably suited to this purpose, but its use is more likely to prevent an overemphasis on one cause or set of causes, and is more apt to contribute to a balanced presentation.

The work of the psychiatrist on psychopathological factors making for war, the mass mind, fears, anxieties, and sense of insecurity of peoples, demagoguery, and the rôle of leadership, can find its place in a synthesis of underlying or fundamental causes of war, such as the historian uses, as also in the tracing of the immediate background of interstate tensions and conflicts. Likewise through the use of the historical synthesis can the research of other social scientists concerned with war find an integration in efforts directed to a common end: the elimination of war and the achievement of international understanding.

NATIONAL CHARACTERISTICS AND INTERNATIONAL RELATIONS[1]

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The last few years have witnessed a tremendous growth of interest in the problem of national characteristics. The problem is an old one, of course, and the interest in it has been continuous throughout the ages, but the approach has altered considerably not only in its character but also in its intensity. In the past it was largely the concern of historians on the one hand, and of journalists and travellers on the other. Now almost all the social sciences have begun to make their contribution to the understanding of national characteristics; not only history but also sociology, anthropology, psychology, psychiatry, psychoanalysis, political science, comparative law, the study of public opinion, and many other related disciplines. Several universities, for example Columbia and Harvard, are engaged in extensive research along interdisciplinary lines. UNESCO, in connection with its Project on Tensions Affecting International Understanding, has initiated a series of investigations of national cultures, including the preparation of monographs on the "Ways of Life" of 16 member nations; intensive psychological and sociological studies of individual communities in France, India, Sweden, and Australia; a comparison of the legal systems of Latin and Anglo-Saxon countries; an experimental-psychological study of English and German youth; a survey of the patterns of authority in Germany, etc. The literature relevant to national characteristics is already extensive, and is increasing rapidly.

So many different methods have been employed that it is impossible in this brief survey to mention more than a few of them. Even a grouping or classification would not do justice to the variety of techniques or points of view. Solely for purposes of discussion, therefore, I would like to consider them under three main heads; first, what may be called an over-all approach, directed toward establishing the general pattern of the national culture and its effect on personality; second, an approach that is concerned with the examination of a number of individuals within a particular nation, and that notes the differences as well as the similarities between such individuals; and third, an intermediate approach that utilizes some of the features of both of the first two.

To what I have termed the over-all approach, the major contributions have been made by anthropologists, and secondarily by psychiatrists. Anthropologists have had long experience in describing the culture of so-called "primitive" peoples, and of late they have attempted to do the same for more complex, modern nations. Ruth Benedict's book on Japan(1), Margaret Mead's book on the United States(2), Geoffrey Gorer's book (3), also on the United States, and the book by Gorer, in collaboration with John Rickman, on Russia(4) are among the most important examples in this area. It will interest a psychiatric audience to note how heavily many of these anthropologists have leaned on principles of explanation which come from psychology, psychiatry, and psychoanalysis. Gorer, for example, in an article on Japan (5) finds it helpful to relate many of the characteristics of the adult Japanese to the severe toilet training to which the Japanese infant is subjected. In the case of the Russians, Gorer leans more heavily on an aspect of behavioristic psychology. Many years ago John B. Watson had pointed out that one of the primary and original sources of rage in the new-born infant is restriction of movement. On this basis Gorer argues that the tight swaddling that Russian parents impose upon infants in the first year of life would have certain very definite, predictable consequences, and he finds in such swaddling a clue to much that would otherwise remain enigmatic in the Russian character.

Among psychiatrists, perhaps the best-known example of what I have termed the over-all approach is the book by R. B. Brickner on Germany(6). Brickner makes use

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of a diagnostic category well known to psychiatrists, namely, paranoia, but he extends it from its customary individual application so as to describe a whole national culture. He does not state—and here he has been misinterpreted—that all or even the majority of Germans are paranoid; he is describing the culture, not individuals, though he does indicate that in such a culture paranoid characteristics in certain persons would facilitate their choice as leaders. In general, however, it is a *cultural* paranoia with which he is concerned.

A great many criticisms have been directed toward the over-all approach briefly described above. I should like to express my own reaction in terms of three general questions, which in my opinion have not as yet been answered in any satisfactory manner.

In the first place, are the descriptions accurate? Do they correspond with the facts? I ask this question because the evidence on which the description is based, and which furnishes the starting-point for the interpretations that follow, is not always presented in such a manner as to carry conviction. Sometimes there is evidence in the opposite direction. Gorer's emphasis, for example, on the severe toilet training of the Japanese infant is not corroborated by the investigation of Mildred Sikkema into the habits of Japanese families in Hawaii(7). Her results indicate that those parents who were born in Hawaii, and who were therefore presumably more "American" in their culture, were actually stricter in the toilet training of their children than were those born in Japan.

Secondly, even if the description is accurate, to what extent is it unique? Does it adequately differentiate one national culture from another? Granting that restriction of movement through swaddling is widespread in Russia, the fact remains that similar restriction of movement is found among infants in many other cultures as well. (See P. Greenacre(8).) In that case, can swaddling really be the clue to the national characteristics of the Russians? In connection with Americans, Gorer refers to the fact that infant feeding is regulated by the clock; the infant is fed according to a strict time schedule, with little regard for his needs or wishes in the matter. In Czechoslovakia, however, a public opinion poll in 1947 also indicated that most mothers fed their infants at regular intervals. The unquestioned authority of the German father has been used (for example by Bertram Schaffner(9)) to explain many aspects of German political behavior. The authority of the traditional Chinese father, however, was at least equally unquestioned. Many other examples could be given of facts that appear to be true of one national culture but which—if I may use a medical expression—are not sufficiently specific to that culture to permit a differential diagnosis.

Finally, it is important to ask this set of questions: Is the over-all cultural pattern true of everybody in that culture? Is it universal within a particular nation? If not, to what extent, in what manner, and with what frequency, do people deviate from such a pattern? These questions have usually not been asked nor answered by those whose descriptions of national cultures we are now discussing. It is important to know whether *all* Japanese subject their children to a strict toilet training; whether *all* German fathers are authoritarian; whether *all* American mothers feed their infants according to a rigid time schedule: In the case of all three of these generalizations there are undoubtedly many exceptions, and their frequency and range require further exploration. We know that class differences may sometimes play an important part; it has been demonstrated(10, 11) that adherence to a time schedule for feeding is much more commonly observed in upper and middle class families in the United States than in working class families. This is only one of a number of examples that could be given of the need to take into account the range of individual and subcultural variations within any nation.

This brings us to the second major approach, namely, that concerned with the examination of individuals. This has taken many forms, of which only a few will be mentioned at this point. Public opinion studies of the polling variety have begun to yield material of value. Although the information so obtained is at a rather superficial level, the method has the virtue of basing its findings on answers given by a

representative cross section of the total population, with minority as well as majority views receiving consideration as part of the total picture. There are serious difficulties of interpretation in many cases. When, for example, we learn that in 1948 the question: "Do you, personally, believe in God?" was answered in the affirmative by 96% of respondents in Brazil and only 66% in France, we would first have to make sure that the words used have the same connotation in the two countries; we would also need to know the relation of this belief to the total complex of religious attitudes of Brazilians and Frenchmen respectively. Similar considerations apply to the fact that, in 1947, 68% of Canadians interviewed expressed themselves in favor of capital punishment as contrasted with only 23% of respondents in the Netherlands. Both of these differences are probably too large to be dismissed as accidental. In any case the method is useful both as a starting-point for further investigation, and also as a means of checking on statements made about "typical" French or Dutch or Brazilian views on these and other topics.

At a somewhat more intensive level, use has been made of a series of interrelated questions designed to make possible quantitative comparisons of the frequency with which certain attitudes or opinions are expressed. In one such study(12) D. V. McGranahan asked a number of interesting questions of boys of high school age in the United States and Germany. There were definite differences between the two national samples, but there was a marked degree of overlapping as well. The German pattern of unquestioned paternal authority was in a sense borne out. To the question: "Do you think a boy is justified in running away from home if his father is cruel or brutal?" 50% of the German sample, and only 30% of the American sample said "no." More Germans than Americans, therefore, accepted the father's authority without question. From another point of view, however, this view of German family structure is seriously challenged; the number of boys stating that the boy *is* justified in running away is 45% of the German total (the remaining 5% expressed no opinion). The apparent exceptions are almost as frequent as those who answer in the expected direction. Nor must we forget the very considerable minority of Americans (30%) who answer the question in the "German" direction. This type of quantitative comparison makes a very real addition to our understanding of the nature of the group differences.

In the book by Schaffner to which reference was made above, interesting use is made of the technique of sentence-completion. One of the sentences used was: "The opposition of a young man against his father is . . . ." The completions on the whole appear to bear out Schaffner's contention that in general the authority of the German father is unquestioned; they include phrases such as "the result of poor training," "a lack of character," "to be condemned," etc. There were some completions that went in the opposite direction, though these were apparently in the minority; for example, "the natural behavior of youth," "the sign of beginning independence," etc. Unfortunately, Schaffner gives no adequate indication of the relative frequency of the two types of completions, nor does he have results from any other national group as a basis for comparison. With these two extensions, the method would appear to have definite value.

Psychiatrists will be interested in the fact that the Rorschach technique is finding an increasingly wide application in the study of national characteristics. One recent study by T. M. Abel and F. L. K. Hsu(13) compares Chinese-born with American-born Chinese, all now living in the United States, and finds the Rorschach to be a valuable instrument for the study of national differences, as well as of the process of acculturation, in which a group of different national origin can be seen to be taking on the patterns prevalent in the country to which they or their parents have migrated. In the community studies now being conducted under the auspices of UNESCO in India, France, Australia, and Sweden, the Rorschach is one of the techniques used for the study of differences among communities as well as among individuals within the same community.

Intensive interviews, modified from the psychiatric and psychoanalytic interviews in wide clinical use, have been recently applied

to the problem of national characteristics. Perhaps the outstanding example is that of the British psychiatrist, Henry V. Dicks (14), who interviewed a large number of German prisoners of war, and described the character structure that he regarded as typical. Among the characteristics that Dicks ascribes to his German subjects are the following: earnestness, over-respect for authority, concern with status, conformity, uneasiness in unforeseen situations, etc. The major query that must be raised in this connection relates to the conditions of the investigation. The Germans were all prisoners of war; they were interviewed by a British officer. Can we be certain that the rapport that prevailed under these circumstances would be satisfactory for the purposes of such a study? In any case Dicks has adequately demonstrated the feasibility of using interviews for this purpose, although here again it would have been interesting to have similar interviews of British or American men under comparable conditions. Mention should be made also of the interviews carried out by David M. Levy(15) in Germany with a view to establishing differences in the background and personality of Nazis and anti-Nazis respectively. His study seems to me important precisely because it keeps in mind the variations as well as the similarities in German national characteristics.

Recently the late Harry Stack Sullivan called attention to the contribution that psychiatrists could make to this whole area through what he called a "Psychiatry of Peoples." He saw the possibility of developing techniques for interviewing a representative sample of a number of different national groups, and through collaboration with other social scientists deepening our understanding of the relation between national culture and personality characteristics. I can only echo his suggestion. A beginning in this direction could probably be made by the judicious exploitation of existing materials. In another context, I have pointed out that many psychiatrists and psychoanalysts have a rich experience with individuals of differing national background, either because their clinical practice has been conducted in more than one country, or because they have had patients or students from many countries. This experience, if pooled and compared, should yield interesting similarities and differences. Because of the selective character of the analyst's or psychiatrist's clientele, however, it would be very much better to extend the interviewing technique to a truly representative sample of a population.

In a third category, intermediate between the over-all approach to a whole culture and the study of individuals, I should like to single out for mention two methods that seem to me to be particularly promising. The first is the study of specific communities, particularly when (as in the case of the UNESCO community studies) the attempt is made to study individuals psychologically as well as studying the community from the sociological or ethnological viewpoints. This method can best make its contribution to the understanding of national characteristics when more than one community within the same nation is investigated, and also when communities in different countries are studied by techniques that are as similar as the differences in culture permit.

A second method in this category that has attracted considerable attention in recent years is that of the content analysis of cultural products. Some years ago S. Kracauer (16) made an analysis of the German cinema as an indication of German national characteristics. Very recently M. Wolfenstein and N. Leites(17) have examined the American film as a clue to the characteristics of Americans. They analyzed the pattern of relationship between the sexes (identifying in the American film the "good-bad girl," who seems to be wicked and glamorous at the outset, but turns out to be a good girl after all, in spite of her glamor); the family background (the protagonist in the film usually has parents who are shadowy or absent; he is more closely identified with the family he himself establishes than the family from which he comes); the relation to authority, etc. Another example of content analysis in this field is the comparison of German and American plays by D. G. McGranahan and I. Wayne(18). One of the interesting aspects of this study is the comparison of the results obtained by this method and those that emerge from the application of atti-

tude questionnaires, reactions of Germans to American moving pictures, etc. On the whole the pattern appears to be fairly consistent.

This description of methods utilized in the study of national characteristics is far from complete, but it is hoped that at least some idea emerges of the interest that social scientists are showing in this field, and the variety of approaches that have been developed. The information that is gradually accumulating should be of very real value in dealing with people of different national origin and background from ourselves. We need to know a great deal about other nations; their ideals, aims, ambitions, and values; the situations that arouse particular emotions and the way in which such emotions are expressed; the patterns of cooperation and aggression, of joy and sorrow, of pride and shame; the relation to authority, etc. The list of things we would like to know could be extended indefinitely.

Such information could have very important practical applications. When we join with representatives of other nations in international conferences, a more complete knowledge of their attitudes and reactions would help to avoid unnecessary misunderstanding and make cooperation easier and more successful. In the history of international relations, generally, it seems highly probable that many errors of judgment could have been avoided if the science of national characteristics had been better developed. It has been suggested, for example, that if Hitler had not so greatly misjudged his "enemies," Great Britain, the United States, and the Soviet Union, he might not have embarked so readily upon his career of imperialist expansion. This is admittedly speculative, but it is hardly speculative to conclude that the better we know other nations, the more likely we are to act sensibly and objectively—and therefore successfully—in our dealings with them. The study of national characteristics is therefore of paramount importance; it should, in my opinion, be pursued along many different lines and through the application of many different methods, so that the results obtained in one way may be validated and corroborated—or challenged—by those obtained in another.

The acquisition of information in this area has one other possible function that should not be overlooked. The opinion is widely held that in the development of friendlier, more cooperative international relations, knowledge about the other nations will have an effect in the desired direction. Research on the relation between information and attitude does, in general, lend support to this view. There are many exceptions, however. Some kinds of information do not affect attitudes, and some individuals retain their original attitudes in spite of the acquisition of, or exposure to, information that theoretically ought to have an influence. It is not entirely clear why some individuals should be affected and others not. Psychiatrists are undoubtedly in the best position to understand the resistances that serve as barriers to change, and to throw light on individual differences in the rigidity and flexibility of attitudes.

Much more information, along many diffent lines, is still needed. This is a field in which not only interdisciplinary, but also international, cooperation is a prerequisite to a completely successful research program. I have tried to indicate some of the contributions that psychiatrists can make to this program, as well as some of the reasons why their colleagues in the other social sciences hope that psychiatrists will join actively in furthering the scientific study of national characteristics.

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DOES FAILURE RUN IN FAMILIES?

A Further Study of One Thousand Unsuccessful Careers [1]

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Nature and Scope of the Study

Students of human behavior have tended to ally themselves with one side or another of a now venerable dichotomy of determinism called "heredity-environment," "nature-nurture," or some similar designation. In the absence of data to the contrary, and sometimes in the face of such evidence, they take a position regarding certain aspects of human behavior that is based upon their individual biases or the "school" they espouse. Only occasionally does the conflict erupt into full-fledged investigations designed to "prove" that any kind of behavior is due either to inherited or to learned factors.

It is not within the purpose of this paper to review the literature on sibling studies, although such material has been gone over. The monograph by Woodworth is a perfectly adequate summary of the kind of work that has been done(1). Unfortunately, there exist few of the type of investigation to be reported here, and our search of the literature proved to be a relatively sterile occupation. In recent years, research in heredity and environment has tended to be somewhat limited in scope. Thus, an investigation of autonomic functions among twins, siblings, and unrelated individuals is undertaken and indicates that there is a descending order of correlation between members of the above groups in various of the autonomically controlled functions—functions that, apparently, are constitutionally determined(2).

The kind of research in which the investigator purposely limits the scope of his study can be contrasted with another kind that attempts to ascribe either to heredity or environment the total adequacy of an individual or group. In this class are to be found such works as those of Galton(3), Dugdale(4), and Goddard(5). The study to be reported perhaps is of this broader kind, which attempts to assess the total personality of an individual as it functions in a given society.

It is not to be thought that the present writers are going to attempt to "prove" anything with regard to heredity or environment. What they have done is to compare with their siblings a group of individuals who have demonstrated their social inadequacy. The reader must decide whether the differences, or lack of them, between the two groups can be laid at the door of heredity or environment, or whether such a decision is at all necessary.

In a recent paper, *One Thousand Unsuccessful Careers*(6), the writers reported a preliminary study of admissions to the Tewksbury State Hospital and Infirmary in Massachusetts. The background of the institution and the kind of people it admits were described in that paper. For present purposes it suffices to say that this institution was founded for the care of the unsettled poor of the Commonwealth of Massachusetts, and, despite its name and the fact that it is medically supervised, it maintains

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The writers wish to thank Dr. C. Winthrop Houghton, superintendent of the Tewskbury State Hospital and Infirmary, and Miss Flora E. Burton, supervisor of social service, Massachusetts Department of Public Welfare, for their many courtesies, without which this study would not have been possible. They wish to express their appreciation, also, to the large number of persons who aided in the laborious task of collecting and analyzing these data. We are particularly indebted to Messrs. Richard S. Sterne, James D. Smith, Vernon H. Huber, Miss Barbara Trask, Mrs. Mary Hennessey, in addition to other students of the Department of Sociology at Tufts College.

the character of the almshouse. Thus, admission to Tewksbury has been arbitrarily regarded by the writers as evidence of an individual's inadequate ability to cope with the demands of present-day society. The results of the preliminary study can be summed up in the following paragraph:

> The results are simple. The individuals show an excess of immigrants; a deficit in formal education, in occupational skill, and in marital success. We do not find a preponderance of catastrophic illness, but we do find alcohol to have been an important factor in the failure of these individuals to make a successful adaptation. Our experience indicates the need of further psychiatric inquiry into this field, as the techniques of psychiatry seem to be peculiarly applicable. The data suggest the possibility of poverty often being secondarily economic and primarily either due to chronic illness or behavior disorder (7).

Although our data indicate that the Tewksbury admissions have certain deficits or handicaps when compared with the general population of Massachusetts, they still do not approach the question of why some persons with particular handicaps do not function adequately, while others with the same personal deficits can be considered successful members of their society. There is a limited literature showing that deviations like feeble-mindedness or delinquency and crime may "run in families," but there has been very little examination of the individual attributes of members of such families. This is particularly true with regard to that class of people who come into contact with large community agencies as a result of their failure to get along.

The present study, then, represents an attempt to look at the families, more particularly the siblings, of men who have demonstrated their inability to participate adequately in the life of the community. Comparisons between the Tewksbury inmates and their siblings in various objective, quantifiable criteria have been made. It was felt by the writers that, at the present stage of our knowledge of these matters, the greatest contribution to the sciences of human behavior can be made by providing such data, leaving to a period of greater sophistication the analysis of subtle factors determining behavior.

The population of the present investigation consists of 400 sets of siblings of Tewksbury State Hospital and Infirmary inmates. The chief criterion for choosing this particular 400 from the 1,000 cases in the original study was the availability of the family for study. Thus a certain number of cases in the 1,000 were eliminated because the inmate was an only child. Others had to be discarded because all the siblings were in a foreign country, or dead, or otherwise not available. Table 1 indicates the availability for study of the siblings of the original 1,000 patients. Some investigation was made in all cases and, of the number on which adequate information could be obtained, 400 families were chosen at random.

TABLE 1

DISPOSITION OF 1,000 FAMILIES IN THE STUDY

Patient known to be only child	30
No information on siblings obtainable	408
Partial information on siblings obtained	105
Completed cases	457
Total	1,000

TABLE 2

CATEGORIES OF SIBLINGS ELIMINATED FROM THE STUDY

Died as children	170
Were never in the U. S.	170
Were in the U. S. but no contact possible	10
Whereabouts unknown	10
Total	360

In the 400 families chosen from the 457 completed cases, a total of 2,142 persons, including the 400 Tewksbury patients, were involved. Of the 1,742 siblings of patients, information on various aspects of their lives has been obtained concerning 1,382 individuals. The reasons for excluding 360 siblings from the study are presented in Table 2.

Worth noting is the small number of siblings who reached adulthood and who have been in this country, who could not be studied. These may represent individuals who have been lost sight of by the family because their careers deviated extremely from family norms or expectations, but so small is their number (less than 1% of the total) that it is unlikely that their exclusion will in any way affect the entire picture.

In summary, then, our study deals with

400 patients at the Tewksbury State Hospital and Infirmary and 1,382 of their 1,742 siblings. The sources of information about both patients and their siblings were varied. In almost all cases, some check was made as to the authenticity of the information from any one source and it was found that there was very little need to be concerned with that problem. As will be seen in Table 3, the major source of information about his siblings in about one-third of the families was the patient himself. It was found that, when the patient knew enough about his siblings to give the information, it was almost invariably accurate. The information was obtained through two or more interviews with the patient. In the most important categories of information—those dealing with arrests and contacts with social agencies—only the data supplied by the Massachusetts Department of Probation and the Social Service Index were used. The informants listed in Table 3 represented the chief sources of information for other kinds of information.

TABLE 3

CHIEF SOURCES OF INFORMATION ON PATIENTS AND SIBLINGS

Siblings	176
Patient	149
Relatives (not siblings)	29
Social Service Index	23
Parents	19
In-laws	15
Patient's wife	14
Friend of family	14
Patient's children	12
Total sources	451

For the 23 families on which information was received chiefly from the Social Service Index, the records of the Index were sufficiently complete to provide data beyond agency contacts.

The sex division of the 1,362 siblings studied was about even. There were 684 males (49.5% of the total) and 696 females. Therefore, our total study deals with 1,084 men and 698 women, when we include the patients themselves.

ARRESTS AND SOCIAL AGENCY CONTACTS

The crucial factor in this study is the difference, if any, in the extent of dependency on public agencies between Tewksbury patients, who have demonstrated their inadequacy in this respect, and their siblings. It is fortunate that there was no need to rely on the reports of the people involved, but that the investigators could go directly to the central clearing houses for information of this kind: the Social Service Index and the State Probation Department. From these records, it was found that in 174 families, representing 43.5% of the total, the patient was the only member to be listed with either the Social Service Index (SSI) or the Probation Department (PR). A summary of the findings from these records is presented in Table 4. One must remember that admission to the Tewksbury State Hospital and Infirmary automatically gives one a record in the Social Service Index.

TABLE 4

INCIDENCE OF PROBATION AND SOCIAL SERVICE INDEX RECORDS AMONG PATIENTS AND THEIR SIBLINGS

	No. pts.	%	Total sibs	%	Male sibs only	%	Female sibs only	%
No record	...	..	968	70.0	421	61.6	547	78.4
SSI but no PR	131	33.0	227	16.4	97	14.2	130	18.6
PR but no SSI	...	..	106	7.7	99	14.5	7	1.0
Both PR and SSI	269	67.0	81	5.9	67	9.7	14	2.0
Totals	400	100.0	1,382	100.0	684	100.0	698	100.0

In two categories of the above table, "No record" and "Probation record but no SSI," the dashes in the "Patients" column indicate that all patients by virtue of having been in Tewksbury have SSI records. It would seem from the above that there is no doubt that the siblings of the Tewksbury patients are making a better adjustment than the patients themselves. Only 30% of the sib-

lings have any record at all, in contrast with the patients, all of whom have records. In the matter of arrests, only 13.6% of the siblings have been arrested, whereas 67% of the patients fall into that category. Certainly one would expect a greater similarity between the two groups if one regarded either heredity or environment in a gross sense as being the determinants of adult adjustment.

Even among those siblings who are listed in the Social Service Index or in the Department of Probation records, the average number of contacts per sibling listed is lower than the number of the corresponding group of patients, as is shown in Table 5.

TABLE 5

AVERAGE NUMBER OF SSI CONTACTS AND ARRESTS FOR PATIENTS AND SIBLINGS WITH RECORDS

	Patients	Siblings
Average number SSI contacts...	5.4	3.5
Average number arrests.....	14.7	10.0

ebriety as the most important single social problem represented in our population.

PLACE OF NATIVITY; AGES OF PATIENTS AND SIBLINGS

Now that it has been established that there is a difference in adequacy of adjustment between patients as a group and their siblings, it is necessary to look into other attributes with the hope that some light may be shed on factors that contribute to the difference.

In their article, *One Thousand Unsuccessful Careers,* the writers showed that there was an excess of foreign-born individuals in that population as compared with Massachusetts as a whole. The same is true in the present study, but to a more limited extent. It must be remembered that, in selecting the 400 families, availability of the siblings for study was the chief criterion. Thus the elimination of families in which the siblings were in other countries had the effect of

TABLE 6

ANALYSIS OF ARRESTS OF PATIENTS AND THEIR MALE AND FEMALE SIBLINGS

	Patients			Male siblings			Female siblings		
Type of offense	No. arrested	% of total patients	% of total pts. with prob. rec.	No. arrested	% of total	% of total male sibs with prob. rec.	No. arrested	% of total	% of total female sibs with prob. rec.
Acquisitive	79	19.8	29.4	31	4.5	18.7	4	0.6	19.0
Procreative	21	5.3	7.8	17	2.5	10.2	6	0.9	28.6
Pugnacious	31	7.8	11.5	25	3.7	15.1	4	0.6	19.0
Drunkenness	236	59.0	87.7	118	17.3	71.1	14	2.0	66.7
Other	149	37.3	55.4	103	15.1	62.0	10	1.4	47.6

Perhaps the clearest picture on arrests can be gained from an analysis of arrests according to type of offense. As can be seen from Table 6, the kind of trouble these people get into is probably the most significant clue we have concerning causes of failure.

Of the sisters of our patients, the small number who have been arrested at all, only 21, makes doubtful the value of the figures for that group in Table 6. The most obvious fact from this table is that drunkenness is perhaps the most important single factor in the failure of patients to get along in society, as well as in the case of their male siblings who also have been in trouble. Indeed, with 87.7% of patients with probation records having been arrested for drunkenness, and with 71.1% of their brothers in the same category, we are justified in considering in-

weighting the sample on the side of the native-born. When, however, the difference in nativity between patients and their siblings is examined, we find very little difference between the two groups. Table 7 gives the distribution of places of nativity of patients, their siblings, and their fathers, as compared with the percentage distribution of places of nativity of the entire Massachusetts population.

From this table it can be seen that a very large proportion of both patients and siblings are second-generation Americans. Of the total number of patients and siblings, 63.5% were born in the United States, as compared with 79.7% for Massachusetts as a whole. But when we look at the differences between patients and their siblings, it is obvious that this small difference is an insignificant factor

in attempting to explain the gap in the ability of the two groups to adjust to the demands of their society.

TABLE 7

NATIVITY OF PATIENTS, SIBLINGS AND FATHERS AS COMPARED WITH POPULATION OF MASSACHUSETTS

Birthplace	Fathers %	Patients %	Siblings %	Massachusetts population %
Massachusetts	15.8	48.0	47.2	68.4
Other U. S.....	11.7	16.5	15.7	11.3
British Provinces..	19.2	13.0	16.8	5.4
Ireland	29.8	12.5	13.2	2.4
Great Britain	5.7	2.0	1.7	2.2
Poland	2.0	2.0	1.1	1.2
Russia	0.5	0.2	0.1	1.5
Italy	2.8	1.8	0.9	2.6
Lithuania	1.5	1.2	0.4	0.5
Finland	0.8	0.5	0.1	0.2
Miscellaneous	4.2	2.3	1.0	4.3
Unknown	6.0	..	1.8	..
Totals 100.0		100.0	100.0	100.0

TABLE 8

COMPARISON OF YEAR OF BIRTH OF PATIENTS AND THEIR SIBLINGS

Birth years	No. of patients	%	No. of studied siblings	%
1850–1854.....	..	..	8	0.6
1855–1859.....	1	0.2	14	1.0
1860–1864.....	4	1.0	43	3.1
1865–1869.....	20	5.0	69	5.0
1870–1874.....	30	7.5	112	8.1
1875–1879.....	51	12.8	127	9.2
1880–1884.....	72	18.0	140	10.1
1885–1889.....	56	14.0	182	13.2
1890–1894.....	41	10.2	168	12.2
1895–1899.....	40	10.0	155	11.2
1900–1904.....	33	8.3	128	9.3
1905–1909.....	25	6.2	82	5.9
1910–1914.....	15	3.8	55	4.0
1915–1919.....	6	1.5	31	2.2
1920–1924.....	2	0.5	10	0.7
1925–1929.....	1	0.2	12	0.9
1930–1934.....	3	0.8	4	0.3
1935–1939.....	..	..	..	..
1940–1944.....	..	..	3	0.2
Unknown.....	..	..	39	3.0

A distribution of years of birth presented in Table 8 indicates that the patients as a group are slightly older than their siblings. The average individual in each group was born in 1888, but the mean for the patients is 1888.38, as compared with 1888.95 for the siblings. (The data on ages are presented in terms of "Year of Birth" in order to avoid the complication involved in a study that stretches over a long period.)

The difference in ages of patients and siblings was also studied in another way. The mean age of the siblings in each family was compared with the age of the patient in that family. This technique yielded a mean difference of 0.26 year, or about 3 months, with the patients as the older group.

FAMILY SIZE AND BIRTH ORDER

The average number of children per family in our study was 4.4, a figure somewhat higher than the average for Massachusetts as a whole. This is to be expected when we consider the large number of foreign-born parents included, whose fertility tends to be higher than that of the native-born population. A distribution of families according to number of children is presented in Table 9. It should be noted that all live births are included in the table.

TABLE 9

DISTRIBUTION OF FAMILIES ACCORDING TO NUMBER OF CHILDREN

No. of children	No. of families	% of total no. families
2	51	12.8
3	74	18.5
4	61	15.3
5	47	11.8
6	51	12.8
7	31	7.8
8	30	7.5
9	24	6.0
10	11	2.8
11	9	2.3
12 and over.....	11	2.8
Total	400	100.4

Of the total of 400 families, there were 175 in which the Tewksbury patient was the only sibling with a record either in the Social Service Index or the Probation Department. A percentage distribution of these families according to size is listed in Table 10.

We can see from Table 10 that, as the size of the family increases, the number of children with SSI or probation records also increases. Although the writers hesitate to offer any hypothesis concerning these find-

ings, it does seem that economic pressure in the larger families may be a factor.

An analysis of birth order has also been made. One would expect that those children with SSI or probation records would be evenly distributed as far as the order of birth is concerned. Thus, in families of two children the expectation is that one-half

TABLE 10

PERCENTAGE OF FAMILIES WITH GIVEN NUMBER OF CHILDREN IN WHICH ONLY THE PATIENT HAS SSI OR PROBATION RECORD

Size of family	%
2	64.7
3	56.8
4	45.9
5	34.0
6	37.3
7	38.7
8	20.0
9	33.3
10	45.5
11	22.2
12 and over	36.4

TABLE 11

COMPARISON OF PERCENTAGES OF CHILDREN HAVING SOCIAL SERVICE INDEX AND/OR PROBATION RECORDS WITH PERCENTAGE EXPECTANCY IN FIRST-BORN CATEGORY

Size of family	% expected in first-born category	% actually in first-born category
2	50.0	62.7
3	33.3	40.2
4	25.0	29.3
5	20.0	15.8
6	16.7	12.6
7	14.3	14.3
8	12.5	12.2
9	11.1	12.7
10	10.0	17.4
11	9.1	8.6

those with records would have been the first-born, and one-half second-born. This expectation is not borne out in the case of some sizes of family, as shown in Table 11.

When the Chi-square test is applied to the data for the first-born position, there is some indication that birth order is significant; but a value of Chi-square in the order of 13.7 for 9 degrees of freedom leaves a probability of almost 20% that the observed differences are due to chance.

When the percentage of first-born subjects with records is compared with similar results for other sibling studies, it is found (8) that the unusual child in the family tends to occur more frequently than expected in the first-born position whether his deviation is of a desirable or of an undesirable nature. This information is presented in Fig. 1.

EDUCATION

Generally speaking, the patients averaged slightly less in years of school completed than did their siblings. Our data on the educational attainment are complete only for 346 of the 400 families, and, when we compute the years of school completed by families, we find that the patients averaged 0.9 grade less than their siblings. It should be remembered that this figure is based on education within a family. Thus, the years of school completed by each patient in the 346 families in which the data were available were matched with the average number of years of school completed by his siblings. Table 12 presents a breakdown of the years of school completed by all members of our study population, where it is known, and compares their attainment with the findings for the adult population of Massachusetts as a whole.

Although Table 12 provides us with a basis of comparison of patients and their siblings with the adult population of Massachusetts, the percentages in various grades for the siblings in particular are low, partially because of the large number of siblings whose education is unknown: about 20%. If then, we limit our statistics on education to patients and siblings whose education is known, the picture changes somewhat. This has been done in Table 13.

Obviously the educational breakdown for the adult population of Massachusetts in Table 12 is not strictly comparable with the data presented in Table 13; yet a comparison indicates that the patients as a whole have considerably less education than the Massachusetts population as a whole, while the sibling group falls between the two. In the case of the adult population of Massachusetts (including those whose education is unknown) some 48.8% had had some high school education; with the siblings, 35.9% had had any high school; and in the case of the patients, only 28.2% had gone that far

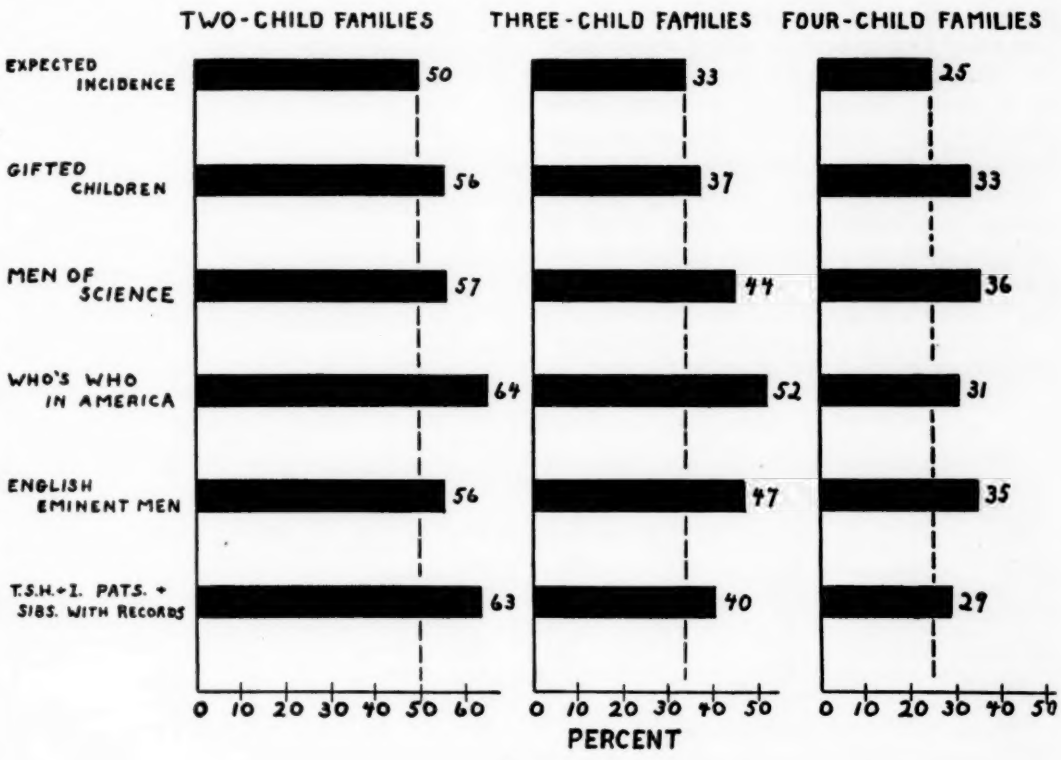

FIG. 1.

TABLE 12

SCHOOL GRADE COMPLETED BY PATIENTS AND THEIR SIBLINGS COMPARED WITH POPULATION IN MASSACHUSETTS OVER AGE 25 IN 1940

School grade completed	Pts.	% of total	Total sibs	% of total	Male sibs	% of total	Female sibs	% of total	Mass. over 25 yrs.
13 and over	13	3.2	53	3.8	24	3.5	29	4.1	10.4
12	20	5.0	168	12.2	65	9.5	103	14.7	19.9
9-11	76	19.0	176	12.7	76	11.1	100	14.3	18.5
7-8	113	28.3	378	27.3	204	29.8	174	25.0	30.6
5-6	78	19.5	215	15.5	110	16.1	105	15.1	8.4
1-4	57	14.2	88	6.4	45	6.6	43	6.2	6.0
0	30	7.5	27	2.0	18	2.6	9	1.3	4.1
Unknown	13	3.3	277	20.1	142	20.8	135	19.3	1.9
Totals	400	100.0	1,382	100.0	684	100.0	698	100.0	99.8

TABLE 13

DISTRIBUTION OF SCHOOL GRADES COMPLETED AMONG PATIENTS AND THEIR SIBLINGS WHOSE SCHOOL RECORDS ARE KNOWN

School grade completed	Pts.	% of total	Total sibs	% of total	Male sibs	% of total	Female sibs	% of total
13 and over	13	3.4	53	4.8	24	4.4	29	5.2
12	20	5.2	168	15.2	65	12.0	103	18.3
9-11	76	19.6	176	15.9	76	14.0	100	17.8
7-8	113	29.2	378	34.2	204	37.6	174	30.9
5-6	78	20.2	215	19.5	110	20.3	105	18.7
1-4	57	14.7	88	8.0	45	8.3	43	7.6
0	30	7.8	27	2.4	18	3.3	9	1.6
Totals	387	100.1	1,105	100.0	542	99.9	563	100.1

in their education. It must be remembered that these figures provide only a rough basis for comparison with the data for the state as a whole. As we have seen, our study population is a much older adult group than prevails in the state population. It would appear, however, that the differences in educational attainment are so great as to be unexplainable on the basis of changes in the educational folkways, which have people going to school longer than they used to.

Before leaving the question of educational differences, it would be of value to check on the general supposition that, because of economic necessity, the children growing up in large families tend to get less education than those in small families. As we can see from Table 14, this does not appear to be the case.

TABLE 14

ANALYSIS OF SCHOOL GRADES COMPLETED ACCORDING TO SIZE OF THE FAMILY

Size of family	Average grade completed
2	6.3
3	8.4
4	7.8
5	7.6
6	7.2
7	8.2
8	8.2
9	7.1
10	6.1
11	8.1

TABLE 15

MARITAL STATUS OF PATIENTS AND THEIR SIBLINGS BY SEX COMPARED WITH ADULT POPULATION OF MASSACHUSETTS IN 1940

Marital status	No. pts.	%	No. male siblings	%	Mass. males %	No. female siblings	%	Mass. females %
Single	192	48.0	183	26.8	36.8	107	15.3	33.9
Married	100	25.0	439	64.3	57.5	500	71.7	53.3
Widowed	43	10.8	24	3.4	4.8	63	9.0	11.5
Separated	32	8.0	9	1.3	*	8	1.1	*
Divorced	32	8.0	8	1.2	0.9	11	1.6	1.3
Unknown	1	0.2	21	3.0	...	9	1.3	...
Totals	400	100.0	684	100.0	100.0	698	100.0	100.0

* Statistics for Massachusetts do not list "Separated."

MARITAL STATUS

A summary of the marital statuses of patients and their siblings will be found in Table 15. It is obvious that, as a group, the patients exhibit much less marital stability than their siblings, or the adult population of Massachusetts as a whole.

The large number of single patients is in line with the findings that alcoholics generally have a higher instance of unmarried persons than the population at large. Equally remarkable is the comparatively high incidence of "Widowed" among patients, as well as "Separated" and "Divorced."

When we look at the male siblings, we find that they tend to have a somewhat "better" record in marital ventures than the adult population of Massachusetts in 1940. In part, the smaller percentage of single siblings compared with the percentage for the adult males in the state as a whole is explainable on the basis of an older group than exists for the entire state. A similar condition exists for the female siblings. They, too, show a higher incidence of married persons than one would expect on the basis of statistics for all adult women in Massachusetts.

Unfortunately, the Bureau of Census figures do not include a category of "Separated." In our study, it was found that there were several persons who, although not living with their spouses, were legally married. Religious as well as other reasons were given for not obtaining divorces or legal separations, but in many cases the real reason was indifference.

OCCUPATIONAL STATUS

One naturally assumes, in dealing with dependent persons, that the level of their occupational achievement would be relatively low. This assumption is borne out in an examination of the highest occupation reached by the patients. By far the largest group

has never gone above the "Skilled Worker" classification. Although the largest group among the siblings occurs at the same level, there are more individuals proportionately in the upper occupational brackets. This information is contained in Table 16, which compares the subjects of our study with the experienced labor force of the United States over 14 years of age in 1940. It should be noted that several persons have been eliminated from this compilation because it is impossible to compare them along occupational lines with the labor force as a whole. Thus, 3 patients who have spent their lives in institutions were eliminated, as well as 15 institutionalized, 7 students, 103 housewives, and 129 siblings whose occupations were unknown.

As in the matter of arrests and social agency contacts, the siblings represent a higher group in regard to occupation, but are generally below the level of occupational achievement for the country as a whole. It is interesting to note that, among both patients and siblings, there is a higher percentage of skilled workers than in the labor force of the United States.

Of further interest is a comparison of the occupational status of both patients and siblings with that of their fathers. This is presented in terms of percentages in various occupational classifications in Table 17.

From this table it would appear that the parents are fairly close to the siblings in occupational achievement and that both these groups have fared better in job achievement than the patients. One might note the increase among the siblings over their fathers in the clerical and sales classification and the decline in the skilled worker group. This undoubtedly represents a change in our economy, which has seen a steady growth in white-collar activities, particularly sales, and a reduction in the percentage of skilled workers available in the labor supply.

TABLE 16

HIGHEST OCCUPATION REACHED BY PATIENTS AND SIBLINGS COMPARED WITH THE OCCUPATIONAL STATUS OF PERSONS 14 YEARS OLD AND OVER IN THE EXPERIENCED LABOR FORCE IN THE U. S. IN 1940

Classification	Pts.	% of total	Siblings	% of total	% of U. S.
Professional, managers, and proprietors	13	3.3	110	9.9	24.3
Clerical, sales, etc.	27	6.8	120	10.6	17.2
Skilled	79	19.9	300	26.6	11.7
Semiskilled	53	13.4	210	18.6	21.0
Unskilled	225	56.7	388	34.4	25.9
Totals	397	100.1	1,128	100.1	100.1

TABLE 17

COMPARISON OF OCCUPATIONS OF PATIENTS AND SIBLINGS WITH THOSE OF THEIR FATHERS, BY PERCENTAGES

Classification	Fathers	Patients	Siblings
Professional, managers, and proprietors	9.3	3.3	9.8
Clerical, sales, etc.	3.9	6.8	10.6
Skilled	32.8	19.9	26.6
Semiskilled	18.8	13.4	18.6
Unskilled	35.6	56.7	34.4
Totals	100.4	100.1	100.0

SUMMARY

The major findings of this study reinforce the hypothesis that failure to get along in our society is chiefly due to behavior disorder and thus is primarily a problem requiring individual rather than social therapy.

In comparing patients of the Tewksbury State Hospital and Infirmary with their siblings, it was found that in 43.5% of the families the patient was the only member to have had any contacts with the police or welfare

agencies. In other families there were additional members who were having trouble, but we very rarely saw a familial pattern of arrests and dependency. It is remarkable that 67% of the patients have probation as well as Social Service Index records, while only 13.6% of the siblings have probation records and 5.9% have both probation and Social Service Index records.

Throughout our investigations we find the differences between patients and their siblings pointing out the superior adjustment of the sibling group in various phases of life. Thus the patients completed approximately a grade less of school than their siblings, fewer of them married, and when they did marry, they were less successful than their brothers and sisters. Whereas the siblings did about as well as their fathers with regard to occupational achievement, the patients represent a much lower level of attainment. As was indicated in *One Thousand Unsuccessful Careers,* the devastating effect of alcoholism in causing failure is an outstanding feature of our findings.

The results obtained in this study would justify the conclusion that attempts to deal with dependency on a mass basis are doomed to failure. Only through programs involving the concept of personality disorder and its individual treatment can we hope to deal with the great problem of the failure of individuals to function in society.

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THE PROBLEM OF DIAGNOSIS IN PARANOIC DISORDER [1]

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As a mental state, paranoia has been recognized for centuries. In modern psychopathology the term refers to those behavior disorders in which the person regards others, and not infrequently the whole world, in terms of a rigid system of delusions of persecution and sometimes of grandeur, but in which there is essential preservation of his personality. Because of the low incidence of commitment we still have a very inadequate conception of this psychosis. Our knowledge of the etiological features, in particular, is limited and our diagnoses are characterized by doubt and uncertainty. Clinical psychiatrists are seldom willing to diagnose a case as paranoia, even when all the symptoms incontrovertibly indicate it.

For the student of paranoia this is not altogether difficult to understand. Psychiatrists do not relish the possibility of becoming involved in the paranoic's intricate delusional system, for his litigious propensities are notorious and his emotional trends are often dangerous. What is not readily acceptable is the tendency to diagnose paranoia as paranoid schizophrenia or to place the two into the same diagnostic category, either paranoid psychosis or schizophrenia.[2] Equally deplorable is the psychiatrist's capitulation to tradition, as in the refusal to diagnose a person as a paranoic because of the alleged rarity of the disorder. While hospitalization of paranoics is indeed rare, this fact is an unsatisfactory reason for rejecting the diagnosis when the symptoms clearly indicate the desirability, even the necessity, of affirming it. Paranoia is far more common in the general population than many investigators seem to realize(4, 8, 11, 16, 18). In view of the attendant confusion the problem of diagnosis, especially of differential diagnosis, takes on considerable importance, both theoretical and practical.

[1] From the Department of Psychology, Ohio Wesleyan University, Delaware, Ohio.

[2] See for example Maslow's and Mittelman's textbook on the behavior disorders, in which the two psychoses are discussed under the category of "schizophrenic reactions"(10).

DEFINITION OF PARANOIC DISORDER

Because of the not uncommon tendency to speak of paranoia and paranoid schizophrenia in almost the same breath, it may be convenient to refer to the two forms of the paranoic syndrome (true paranoia and paranoid—better called paranoic—condition) by the term *paranoic* disorder. The term "paranoid" is thus reserved for paranoid schizophrenia. While the distinction may not be fundamental it is convenient and practical.

Paranoia is characterized by persistent systematized delusions, the preservation of the personality, absence of hallucinations, and heightened affectivity, particularly hatred. The paranoic patient habitually sees biased meanings, is suspicious, and asocial. While on the surface his conduct is not necessarily disturbed, inwardly there is a rigidity of thought and a lack of capacity to form correct judgments concerning those aspects of his environment that concern his delusional trend.

Paranoid (or paranoic) condition—also called paranoid state—is less easily distinguishable from paranoia than is conventionally recognized. The distinction cannot, certainly, be accepted uncritically. This disorder lacks the extreme logical systematization of paranoia, but it seldom exhibits the fragmentation and bizarre delusional trend of paranoid schizophrenia. It is a "quantitatively reduced paranoia"(15).

In view of the difficulty of distinguishing paranoid condition from true paranoia the persistence of the distinction calls for an explanation. There are in the main two reasons for the distinction. The first is largely traditional, the second has some basis in fact.

The two were distinguished by early investigators, notably Kraepelin. This fact, the authority of prestige and tradition, plays an important part in psychiatry, as in all branches of medicine. Because paranoia is rarely encountered in hospitals the clinician will, when he comes face to face with a case, refuse to accept his own better judgment and

classify it as a case of paranoid condition, even of paranoid schizophrenia. Thus an undetermined number of true paranoics are never given their deserved diagnostic label. Typical of this timidity in the face of medical tradition are the following two examples. In staff meeting a female patient was described as having all the symptoms of true paranoia. The doctors had agreed on this diagnosis. One of them, however, remarked: "One hesitates to diagnose any case as true paranoia. However, we may not be able to escape this diagnosis in the present patient." She was, nevertheless, officially entered in the hospital records as a case of paranoid condition. A second patient, a man in his late forties, was presented at staff with the diagnosis of true paranoia. The official entry in the case records reads: "The members of the staff preferred to classify him as a case of paranoid condition." [3]

The second reason for the distinction has an empirical basis. Paranoid condition exhibits less rigidity, less coherence, in the organization of its delusions, and occasionally a pronounced distortion and not merely an exaggeration of dominant personality trends. Inasmuch, however, as the elimination of paraphrenia, which is characterized by hallucinatory trends, is a growing practice among American psychiatrists, the most important differential symptom is thereby made useless. The discontinuance of paraphrenia as a clinical category simplifies our understanding of paranoia and paranoid condition. It avoids the complicating factor of hallucinosis, on the one hand, and reduces the error of diagnosing paranoid condition as paranoid schizophrenia, in which category paraphrenia is now more and more placed, on the other. Until this differentiation is universally accepted, psychiatry will perpetuate an old confusion. Most of the confusion might be eliminated if we dropped the adjective "true" from paranoia and described paranoid condition as differing from paranoia only in degree. So conceived paranoia lies at one end of the scale of a psychological continuum and paranoid condition at the other, the two coming so close at times that the greatest clinical and diagnostic skill cannot distinguish them, because the difference does not exist. In this way we arrive at an operational definition of the paranoic syndrome. Paranoia and paranoid condition differ only in the somewhat looser organization of the delusional system in the latter. Where this distinction cannot be found the two are identical; for "a difference that makes no difference is no difference"(5).

[3] This is not even to mention the fact that many clinical or medical directors of mental hospitals are wholly unaware of the existence of cases of paranoia in the files of the hospitals for whose administration they are responsible. In a recent study of paranoic cases in 5 midwestern mental hospitals, the writer was informed that no cases of true paranoia were on record in the hospitals surveyed. In each case, nevertheless, he found such cases in the files—from 2 in one hospital to 6 in another.

Sociogenic, Psychogenic, and Associative Trends as Diagnostic Aids

In view of the difficulties that beset both clinicians and investigators in the study of paranoic disorder we offer in this article additional criteria for both specific and differential diagnosis. It is not necessary here to discuss at length the conventionally recognized symptoms of paranoia and paranoid schizophrenia. It is very doubtful, furthermore, that the proliferation of types, so dear to the heart of the taxonomist and the textbook writer, has either any theoretical or practical value in understanding the paranoic disorders. The clinical picture of every paranoic case, regardless of its label, reveals the same fundamental pattern: an indignant and suspicious person with a logic-tight delusional system. In all other respects he appears normal, intelligent, and, on the whole, socially acceptable. His judgment is impaired only in relation to his delusional system. He almost never admits that there is anything wrong with him, and his delusions are well-nigh unshakeable. To this extent we say he lacks "insight." He has no hallucinations. The little disorder that exists in his conduct is always consistent with his delusional system. The onset of the disorder is slow and relatively late—or at any rate it is recognized relatively late, generally between the ages of 35 and 55. The average age is 45.6 years, in our own sample.

Paranoid schizophrenia, with which paranoic psychosis is not infrequently confused,

presents on the whole a clearly different clinical picture. While many paranoid schizophrenics present an intact personality on first impression, they are in fact invariably bizarre or eccentric in their delusional systems. The classic symptom of apathy or impaired affect marks the schizophrenic clearly off from the rather emotional paranoic patient; and while anger and hatred are common symptoms, the schizophrenic's affect soon "burns out"(15). The onset of paranoid schizophrenia is slightly earlier than that of paranoic disorder, and on the whole less insidious. Hallucinations, particularly auditory and visual, are fairly common.

We have called the foregoing symptoms of paranoia and paranoid schizophrenia the conventional or "classic" symptoms. They play a crucial role in all diagnoses, both specific and differential. We wish now to propose an additional set of factors as an aid to more accurate diagnosis. These factors were found repeatedly in an extensive investigation of 125 cases of paranoic psychosis (paranoia and paranoid condition) and an equal number of cases of paranoid schizophrenia.

The Family Pattern.—The families from which a large number of the paranoic patients in our sample come are either severely authoritarian or excessively dominating and critical. The authoritarian family is harsh, suppressive, and frequently cruel. In many cases one or both parents show marked neurotic and even psychotic trends. They dominated, controlled, and humiliated the patient during his growth into adulthood. The usual consequence was to set up patterns of hatred and aggression in the child, which, because of his fear of his parents, he was impelled to repress or inhibit. His hatred grew into a permanent mode of adjustment, so that for the rest of his days he approaches people with the proverbial chip on his shoulder. If later there is only hatred remaining it is indicative of a deeply frustrated need for affection and acceptance. The paranoic hates his parents because they were unkind to him, and he is suspicious of them because he resented the injustice of his treatment by them. The injustice is all the more intense in view of the fact that, like every child, the potential paranoic is crushed by the disparity between the idealized and the actual parents. Our case histories are a clear and eloquent demonstration of the principle that the influence of affectively distorted parents distorts in turn the affective life of the child who, when he himself becomes a parent, transmits the distorted pattern to his own children.

As a consequence of his early affective frustrations and parental harshness or cruelty the child tends to withdraw from normal social contacts. As a consequence of his isolation he fails to develop the capacity of role-taking which is indispensable to successful living. He experiences many social failures, for he cannot successfully adjust to others. He is thus impelled, in order to maintain his self-esteem, to find reasons for his failures. His explanations are not rational but emotionally satisfying reasons. Thus, his later delusions, especially those of persecution, are his rationalizations of his failures, and his chronic rage is his method of retaliating against the cruelties and injustices that he has suffered.

Of the 125 cases of paranoic disorder 66 (52.8%) came from the severely authoritarian and 23 (18.4%) from the dominating and critical type of family.

The paranoid schizophrenic's family background is more varied. A trait that nevertheless stands out most often is rejection or neglect. Second in importance is parental indulgence. Because he was overprotected his infancy was prolonged, and in the face of difficulties and failures he tends to regress to a less effective, more infantile, mode of adjustment. Many a paranoid schizophrenic in our sample is still "mamma's baby." His infantilism obviously is despised in the world of adults, and so he does his best to renounce it. He seldom succeeds, for the pattern was too deeply stamped in him in his childish temper tantrums, rebelliousness, autoeroticism, and the like.

In the 125 cases of paranoid schizophrenia the correlation between their psychosis and family type is as follows: 42 (33.6%) belong in the "neglectful" category, 8 (6.4%) are in the severely authoritarian family, 39 (31.2%) fall into the dominating and critical, and 20 (16.0%) come from the "normal" or permissive type.

Critical Life Situations.—A second set of

criteria that serve the purpose of differential diagnosis is that of critical life situations. Our biographical data are replete with such crises as failure, divorce, the death of a loved one, and the like, which while they may not be predisposing are nevertheless precipitating factors in the development of paranoic behavior. Because of a boundless ambition the paranoic individual drives himself to achieve goals that frequently are beyond his capacity. Failure thus creates an intense feeling of worthlessness, loss of confidence in himself, and a tendency to withdraw from the scene without, however, emotionally giving up the battle. Once the core of seclusiveness, failure, and a general distrust of others becomes established in the individual, it goes almost without saying that, barring exceptionally favorable circumstances, the paranoic will react to later situations in terms of the established pattern.

The paranoid schizophrenic, lacking the intense drive for achievement of the paranoic individual, has fewer failures. More significant is the fact that the 2 psychotics differ in their reaction to failure and other critical situations. The paranoic's rationalization almost never leads to the regressive behavior so characteristic of the schizophrenic patient. The former continues his struggle, whereas the latter is more likely to give up. This situation is in accord with the generally observed fact that psychotic reactions seldom make the strong inroads on personality when the individual does not surrender to isolation and withdrawn apathy. Attack may destroy the situation but it preserves the personality; retreat preserves the situation but destroys the personality(11).

Marital Discord.—Almost every paranoic patient is plagued by domestic conflict. It appears in 98% of all the married and divorced cases put together—a staggering figure. His failures are not due, as psychoanalytic opinion would lead one to believe, to sexual difficulties as such, but to the exaggerated and distorted affectivity that disturbs his relations with his spouse. Marital compatibility is even at best a delicate and unstable equilibrium, and when it is assaulted by the chronic hostility and anger of the paranoic individual it cannot survive.

The paranoid schizophrenic's married life is also full of discord, but in the full context of his psychological make-up it is of minor importance. The more important fact about his romantic life is that more often than not he does not marry. Sixty-three cases (50.4%) are single. Only 26 cases of paranoic individuals (20.8%) are single. In view of the average age of the schizophrenic cases —40.5 years—this low marriage rate is significant.

The foregoing differentials are roughly sociogenic; they are social, or group-experiential, characteristics. The next set of differentials is psychogenic, characteristics that are primarily individual-psychological. While the sociogenic and psychogenic characteristics are in fact inseparable they are distinguished here largely for reasons of emphasis.

Various researchers have found what our own data fully support, that almost the entire prodromal history of the paranoic patient reveals a characteristic psychological make-up(14, 15). The prepsychotic personality consists of asocial trends, uncontrollable temper, rigidity, a suspicious and jealous nature, a brooding and combative disposition, egocentricity, and extreme ambitiousness. The paranoid schizophrenic individual has some of these traits also, but his affect is weak, his anger is characterized by irritable excitement rather than chronic hatred, and he is decidedly deficient in drive and ambition.

Personality Type.—While the validity of using the Jungian typology of introversion and extraversion in describing psychotics is open to question it has its usefulness as a diagnostic aid. Of the 113 cases regarding whom we have some reasonably reliable data 39 (34.51%) are introverts and 74 (65.49%) are extraverts. Paranoics are thus seen to be predominantly extraverted individuals.

Paranoid schizophrenics are for the most part introverted, although the withdrawn attitude lacks the extreme aloofness of the paranoic individual. Of the 115 cases regarding whom we have information 74 (64.34%) are introverted and 41 (35.66%) are extraverted. Clearly, the paranoid schizophrenic is generally introverted.

Dominance and Submission.—Since the hospital records carry very little information

on these traits we have data on only 44 paranoic and 61 paranoid schizophrenic cases. To these figures we are able to add, on the basis of interviews, observation, and inferential evidence, 12 cases of paranoic disorder and 9 cases of paranoid schizophrenia.[4] Of the 56 paranoic patients 40 were clearly dominant. Sixteen were characterized by extreme rebelliousness, which is an incipient form of dominance. There were no truly or markedly submissive paranoic cases in our sample. A few who appeared to be cooperative were probably "resigned paranoics"(19). Of the 70 cases of paranoid schizophrenia 52 were submissive and 18 were dominant. Here, once more, the differential is clear-cut and this fact should be useful in differential diagnosis.

Emotional Capacity.—Paranoic psychosis cannot be understood apart from a knowledge of the affect-potential of the patient. Our biographical material is replete with emotional turmoil dating back in most cases to the early life of the patient. Anger and rage are omnipresent, and hatred of others is an almost invariable component of his emotional organization.

The paranoid schizophrenic patient, on the other hand, exhibits throughout his prodromal period an emotional indifference. While he is capable of hatred, by the time he reaches the psychotic stage his hatred seems to "burn out"(15).

Temperament.—The relationship between paranoic disorder and temperament is readily established. Our data leave no doubt about the matter: the paranoic individual has a pessimistic and gloomy temperament. Only 6 of the 111 cases on which we have reliable data are "cheerful," "optimistic," or "sanguine." The rest, or 94.59% of the total, are described as "depressed," "gloomy," "irritable," and "spiteful."

The relationship between paranoid schizophrenia and temperament is not clearly defined. There is neither a clear optimism nor a marked pessimism. To the extent that a tendency is discernible it lies in the direction of indifference.

Motivation.—Our biographical material, as well as a substantial body of published evidence, shows that paranoics exhibit an early self-assertive attitude and "premature" ambitiousness. The paranoid schizophrenic, on the other hand, is a rather passive individual, who lives mostly in his fantasies. His ambition is noted by its absence.

Forty-one cases of paranoic disorder (32.08%) showed positive evidence of strong ambition. In 26 cases (20.8%) there is ambitiousness, but its intensity is undetermined. One case, which is atypical in other respects, is lazy and wholly devoid of ambition, relying largely on his mother for support and direction. In 57 cases (40.06%) there are no available data.

Unmistakable signs of ambition are present in 18 cases of paranoid schizophrenia, or 14.4% of the entire group. Thirty-two cases (25.6%) are practically impossible to evaluate on this trait, and in 75 cases (60%) no information is available.

Intelligence.—Our investigation has brought to light a clear difference in the intellectual capacity of the 2 types of psychotics. The paranoic patients generally rate much higher than paranoid schizophrenics in their performance on standard intelligence tests. This conclusion is borne out by the researches of other investigators(3). The majority of paranoid schizophrenics have average intelligence. None is very superior, but there are 4 cases (3.2%) of the paranoics with very superior intelligence. Forty-four cases of paranoic disorder (35.2%) have superior intelligence in contrast to 18 cases, or 14.4% of the schizophrenics, who are in the same category. There are only 9 paranoic cases (7.2%) in the low normal or dull group, whereas there are 20 cases (16%) of schizophrenics in this group. Significant is the fact that there is only one paranoic case (0.8%) with border-line intelligence, whereas there are 8 cases (6.4%) among the paranoid schizophrenics. There are no feebleminded cases in the paranoic group, whereas there are 6 cases among the schizophrenics—5 morons and 1 imbecile. No information is available for 8 paranoics and 10 schizophrenics.

There are 3 main associative trends, which can in no way be construed as etiological, but which occur with sufficient frequency to serve as diagnostic aids. These trends are

[4] By "inferential evidence" we refer to such descriptive entries in the case records as, "He had to have his way all the time," "He seldom took the initiative," and the like.

homosexuality, constipation, and essential hypertension.

Homosexuality.—Psychoanalysts have from the very beginning claimed that an important trait of the paranoic individual is passive homosexuality(6, 7). Our own data also indicate the presence of a repressed homosexual compulsion in paranoic patients and more overt homosexuality in paranoid schizophrenics. The latter frequently experiences "homosexual panic," whereas in the paranoic patient this panic is usually absent. Fifty-seven of our paranoic cases (45.6%) are characterized by homosexual tendencies, overt or repressed. We have no information on this subject in 68 cases (54.4%) and so can neither affirm nor deny the presence of homosexuality in them. Forty-four cases of paranoid schizophrenia (35.2%) are homosexual. No information is available in 81 cases (64.8%).

Constipation.—The association of constipation with paranoic psychosis has been noted by a number of workers(1, 2). While our figures showing an association are lower than those of other investigators, the relationship does exist. Twenty-nine paranoic cases (23.2%) have clearly marked constipation; 9 cases of paranoid schizophrenia (7.2%) have this disturbance.

Essential Hypertension.—A positive correlation between the emotions and essential hypertension has been established by numerous writers(9, 12, 20). A similar relationship has been found to obtain between high blood pressure and paranoic disorder(13, 17). Our own investigation leads us unmistakably to the same conclusion. Fourteen paranoics (11.2%) have normal blood pressure; 57 (45.6%) have high pressure; and 38 (30.4%) have low pressure. We have no information on 16 cases (12.8%). The paranoid schizophrenic presents a strikingly different picture: 14 cases (11.2%) are normal; 18 cases (14.4%) are hypertensive; and 93 cases (74.4%) have low blood pressure.

Summary and Conclusion

The purpose of this article has been threefold: (1) to call attention to the deplorable situation regarding the reluctance of most psychiatrists to diagnose paranoic disorder where such a diagnosis is clearly indicated; (2) to affirm that the confusion between paranoic disorder and paranoid schizophrenia, where it exists, is largely unnecessary; and (3) to render differential diagnosis of these two psychoses more certain and accurate by the addition to the classical symptomatology of several sociogenic, psychogenic, and associative trends that occur in these psychoses with high statistical frequency. Thus in addition to the well-known symptoms, the paranoic patient is found to have grown up in an atmosphere of suppression, harshness, hostility, and frequently of brutality. The paranoid schizophrenic is less likely to have been reared in this type of home. Diagnosis should take into account, furthermore, the prepsychotic personality of the patient. The diagnostic value of the prepsychotic personality, in our judgment, has been insufficiently recognized by diagnosticians and psychotherapists. The same observation obtains in regard to the other factors that we have briefly described.

On the basis of our clinical and biographical data we believe strongly that, if all the crucial experiences in the life history of a patient were known, we would find no sharp breaks between the prepsychotic and the psychotic make-up of the individual. It is universally recognized by clinicians and competent investigators that paranoic psychosis has a slow and insidious onset. The onset in only 2 cases in our group of paranoic disorder is described as sudden or acute. Interestingly enough there was sharp disagreement among the examining psychiatrists concerning the diagnosis of these cases. The factor of age alone clinched the decision! This factor is a tenuous basis for differential diagnosis in the face of the type of rich case material to which we have called attention.

Given full knowledge of the paranoic's family setting, his successes and failures, the trend of his dominant emotional and intellectual strivings, his conception of himself in his own eyes and, as he believes, in the eyes of others, we are able not only to make a more adequate diagnosis of the patient but to predict the possible outcome of his adjustment to the whole vast complex of his interpersonal relations.

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EXAMINATION OF THE COMPLAINING WITNESS IN A CRIMINAL COURT [1]

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In this psychiatrically minded era we find an increased interest in the study of crime. The focus of attention heretofore has been on the offender with little emphasis on the complainant. Legal technicalities leading to arrest and prosecution operate in such a way as to imply guilt. The arrest, fingerprinting, indictment, and all related preliminary procedures in themselves place the accused in a disadvantageous position. By the same token the complaining witness enjoys immunity as well as the support of the social structure in which he lives.

The role of the court psychiatrist is not to investigate the crime but the criminal. It follows from this that our studies of the criminal could be more valuable were we able to evaluate the plaintiff as well. In clinical psychiatry we repeatedly emphasize the need for all available information. While the complaining witness can be examined and cross-examined in the courtroom he becomes available to the psychiatrist only upon his own consent and then with the approval of the court. It is for these reasons that our material on this subject is limited.

In the Psychiatric Clinic of the Court of General Sessions in the City of New York all felony offenders appear for psychiatric examination prior to sentence. This group of close to 3,000 a year includes individuals of both sexes, different age groups, social, racial, and religious representations in the community. Through their delinquent acts they cover the range of offenses listed in the Criminal Code. The need for expanding the field of study to include the complaining witness is particularly great in some of our cases, principally those dealing with sex offenses.

Criminal behavior may be defined as the acting out of unconscious drives. This theme has been adequately studied and there is a rich literature on the subject. We know, furthermore, that the attitudes toward a criminal are reflective of what lies in the unconscious of society. In assuming the role of accuser the complainant may be acting out unconscious drives that he projects upon the accused.

The material that may be obtained from a witness as he offers it in a courtroom is less informative for purposes of psychiatric evaluation than what might be obtained in a medical interview. This we know to be so in the case of the offender. From the limited material upon which this discussion is based we are led to the belief that broader facilities for the examination of the complainant would add to our knowledge in the field of criminology.

The opportunity presented itself to examine the complainants in a number of cases involving sex offenders. Where the witness was a minor the participation of the mother was a complicating factor. This we discovered to be owing to the fact that the charges against the accused incorporated the hostilities of both mother and child, even though technically the accusations stemmed from the child.

The commission of a crime or the alleged commission of a crime provokes in people a chain of reactions that are colored in greater or lesser degree by their own unconscious drives, needs, fears, or fantasies. There is a heightening of tension that may involve an entire community and seriously interfere with the administration of justice. Borchard, in his review of 65 erroneously convicted individuals, affords an excellent example of this dynamic formulation.

The following case summaries from our own material illustrate once more that convicting the innocent might at times be prevented through the objective examination of the complaining witness.

Case 1.—The defendant is a 38-year-old Negro male who was indicted on a charge of attempted

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rape and after many months of pleading his innocence agreed with his attorney to take a plea of impairing the morals of a minor. The complainant was the man's 12-year-old daughter.

The criminal history of the defendant indicated that he was arrested in 1929 in another state where he was convicted on a charge of attempted rape. He served an 11-month sentence. The rest of the history was essentially negative. He was married to his present wife in 1939 but lived with her in a common-law relationship for a number of years. The complaining girl was an issue of this relationship and there was a 15-year-old halfbrother from the mother's previous marriage.

The defendant was cooperative for the examination and gave a good deal of information about himself. He reviewed his previous crime without hesitancy and indicated that the arrest occurred when he was about 20. His work history as well as other social adaptations appeared to be quite satisfactory. A social history submitted through the Probation Department of the Court of General Sessions essentially corroborated the man's story.

On the night in question the defendant returned home at about 2 a.m. and was moderately drunk. He demanded that the wife prepare him some food, which she refused to do, and an argument ensued. Shortly thereafter the wife left the apartment for the home of a relative living nearby, stating that she was "fed up" with the defendant. The complainant then prepared some food for her father and later the father, daughter, and stepson retired to their respective sleeping quarters.

Early the next morning the complainant awakened her halfbrother and asked him to "run and call mother because Daddy did something bad to me." The boy did not see the father about, and directly went to the home of his uncle and called the mother, repeating to her the girl's statement.

The defendant's wife hastened to her apartment and shortly after her arrival mother and daughter set out for a nearby police station. The mother informed the police that her husband had just raped his own 12-year-old daughter. They suggested medical examination at one of the hospitals.

An immediate report was submitted to the police to the effect that the girl was not virginal, that there was evidence of sexual activity but nothing to indicate "recent assault." On the basis of this information the police requestioned the girl, and she altered her story by stating that the father had committed rape upon her 2 weeks previously, but on this date had merely tried again. At about 10 a.m. the police arrived in the apartment and found the defendant still asleep. They awakened him and asked him to go to the police station, where he denied the accusation.

His allegations of innocence were not acceptable and he was placed under arrest and subsequently indicted by the Grand Jury. The girl was taken to the Children's Aid Society, where another medical and gynecological examination was performed. The report was essentially the same as the one submitted by the hospital and apparently its wording did not provoke any suspicion on the part of the police and District Attorney in charge of the case. Retrospectively it is apparent that the accusation of a young girl against her father had more credulity and she was permitted to alter her story.

The complaining daughter though 12 years of age is a precociously developed young woman. She is as tall as her mother, but somewhat heavier in weight. She was judged to weigh about 150 pounds and was about 5'5" in height. Her breasts are unusually large for a girl of 12 and it would be difficult for a casual observer to think her younger than 18.

At first the girl repeated the story she had rendered so many times previously. When asked to explain the findings of the medical report, which indicated penetration long prior to the day of accusation, the girl became flustered and tears appeared in her eyes. She was assured at this point that whatever material she revealed truthfully would not be held against her and that no accusations would be made. She proceeded to relate the following story: The father treated her and her brother very well but argued with the mother frequently. She was unhappy about it but sided with her mother, agreeing that the father had no business coming home drunk. She added that the parents afforded her a limited amount of sex education, which consisted essentially of warnings. The father verbalized his feelings on this subject by telling the girl, "If I find out that you are bad I will kill you."

The young lady proceeded to relate that about 6 months prior to the date of her father's arrest a young man of about 16 forced her to have intercourse with him by taking from her a favorite scarf. Allegedly fearing the boy's threat she continued to have intercourse with him for several months. Two weeks before the father's arrest the girl discovered that a friend and schoolmate of hers was pregnant and that the authorities were contemplating "sending her away." Fearing that she might be pregnant she *recalled particularly the warnings of her father and became panicky.* She welcomed the argument between the parents, and her mother's departure from the apartment provoked in her a self-saving fantasy. She knew that the father was drunk. She was furthermore aware of the mother's hostility to the father. She had the feeling, she said, that if the father could be blamed for *her loss of virginity he certainly could not kill her.* At the same time the authorities would not deal with her as they did with her friend. She proceeded to act out her fantasy.

What we consider of interest in this case are the following.

The girl though precocious in her physical development was nevertheless just entering puberty. She feared her father and his prohibition of sexual activity. Responding to her own instinctual drives she entered overtly into a love relationship that provoked much guilt feeling. This combined with unconscious Œdipal wishes stimulated in her a great deal of hostility, which she acted out when she accused her father of rape. By this accusation she indeed gratified her Œdipal wish and at the same time punished the father for having told her

that it was bad to gratify her sex impulses. She went one step further in acting out her infantile fantasy when she made the statement, "If it is father who did this to me they could not blame me for being bad."

Of legal interest we find that the history of a previous conviction for a sex offense placed our defendant in a particularly precarious position. The District Attorney apparently was little concerned with the medical report that was at least suggestive of contradiction in the girl's story. He made much issue of the fact that the defendant had previously been convicted as a sex offender. He made no secret of his opinion that if the man had gone to trial before a jury this record plus the testimony of a "young innocent girl" would more than suffice to convict the man as indicted. That the District Attorney was justified in his opinion is corroborated by the unwillingness of the man and his very able attorney to go to trial. They too felt that the complainant would be a most impressive witness.

CASE 2.—The defendant is a 35-year-old white male who is accused of sodomy and pleaded to impairing the morals of a minor. The plaintiff was his own 9-year-old son.

In this case the defendant, a periodic drinker, acted out latent homosexuality with his own son. The boy, on the other hand, effeminate in appearance and mannerisms, undoubtedly welcomed the father's behavior, which was provoked by a state of intoxication. It is our opinion that a psychiatric examination of both father and child at the time of arrest rather than after the conviction could have proved helpful in the administration of justice.

CASE 3.—The defendant is a 20-year-old single Negro male with no previous arrests who was convicted by a jury as guilty of carnal abuse of a child. He was arrested on complaint of an agency acting on information obtained from the mother of a 7-year-old girl.

Mrs. W. stated that during the evening of October 26 she was informed by her daughter that the defendant had taken her underneath the stairs of the main floor hallway and raped her. Immediately upon gaining this information the mother took the child to a hospital where the diagnosis was given as "possible rape" but added that "a smear and hanging drop was sent to the laboratory and reported negative for spermatazoa." The child was re-examined 3 days later, at which time the doctor found no physical evidence of any injury to the child's genitals or anal orifice.

During the psychiatric examination the defendant gave the information that he had reached the third term in high school, served in the army for about 18 months, but had received an "undesirable" discharge because he had violated some rules. He did not commit any crimes while in the military service. He was irregularly employed as a laborer and delivery boy. He was of normal intelligence with an IQ of 99. The young man denied molesting the child and added that he had visited the home as a guest of the mother and claimed that this lady had "flirted" with him on several occasions. The child and her mother were the chief witnesses against the defendant and the jury found him guilty.

Psychiatric examination of the mother and child was suggested. The child was seen first and stated that she was 7 years of age and in the second grade at school. She said that her parents were separated and recalled at this point an instance during which her mother had thrown an ash tray at her father, lacerating his forehead. The child understood this to be related to the father's drunkenness and abuse of the mother. The youngster added that the mother entertained many visitors, whom she called "uncles," and added on further inquiry that one was a "real uncle" and the others were friends of the mother. This included the defendant. The pertinent content of this child's productions evidenced that she had a good deal of knowledge of sexuality and referred to the male genital as "the thing." She was the oldest of 3 children and expected by the mother to take care of the younger siblings during the mother's absences from home, which were frequent. On the day of the alleged offense the child was late in returning from an errand and this angered the mother because the latter was ready to go out. The mother delayed her own departure long enough to scold the child, who offered no excuse for her tardiness. About 24 hours later the child offered her explanation for lateness on the previous day and made the accusation against the young man. Her story varied as to details and the self-contradictions were apparent.

The mother was herself evasive and circumstantial. We wish to relate how she dealt with the situation from the beginning. Her earliest complaint included the statements that on inspecting the child she saw "sores" about her genitals and "blood on the panties." This information was given to the police. Later when presented with the medical findings she altered her story to the effect that the "sores" were "warts" and ignored the statement as to their duration. The blood "may have been just a stain" and the absence of findings by the physicians she dismissed with the remark, "Doctors can make mistakes, too, can't they?" This comment about doctor's mistakes was produced after her admission that she really had not seen blood.

It was impossible to get both mother and child in this examination to give their material without resorting to contradictions. The defendant, however, both on the witness stand and in the psychiatric clinic produced a fairly consistent story. He flatly and unequivocally denied molesting the girl. He admitted flirtation with the mother and revealed that he had avoided intercourse with her, implying that she had had too many men.

What appears to have occurred is the following: A woman of 25 is separated from her husband and entertains men in her home. Her children witness her flirtations with her admirers, one of whom is the defendant. The plaintiff, aged 7, is rather harshly dealt with by the mother. She is expected to run errands as well as to assume responsibility for the care of the younger siblings

when mother absents herself from the home. The child is critical of the estranged father but suppresses her hostility toward the mother. Finding herself berated for lateness she conjures up a story that the defendant, namely, mother's friend and fantasied lover, rapes her. The mother herself allegedly rejected by the defendant acts out her own hostility. She reports blood and sores where none existed. Having supported her child's accusations "on the record" she is unwilling to correct her mistaken perceptions but rationalizes with such remarks as "the doctors can make mistakes" and "the sores may have been warts."

Were it not for the fact that a jury convicted the defendant these fantasies in action would not concern us here. However, we are presented with the problem of a young man convicted of carnal abuse on such contradictory evidence and notwithstanding the two medical reports, which negated rape or any evidence of physical aggression upon the child. This is another example supporting our contention that in sex offenses psychiatric examination of all parties concerned is indicated.

SUMMARY

The psychiatrist in his approach to the problem of crime finds ample opportunity to examine and evaluate offenders. The possibility of obtaining first hand information from and pertinent to the plaintiff is circumscribed by the "rules." A witness is required to appear in court and testify under oath but we cannot demand of him that he appear for psychiatric examination. This is only one of the many advantages the accuser enjoys over the accused.

Substantive and procedural regulations governing the administration of justice place all emphasis on "facts." What is "fact" is left to the judge and jury to decide. The assumption is that fact is a phenomenon in reality. Our experience places us in the group of those who substantially contend that "facts" establishing the guilt of an accused person are not always realistic in nature. This is particularly so in instances where crime has been committed against an individual. The acting out of unconscious drives leads not only to acts of aggression called crime but also to false accusations resulting at times in erroneous convictions of the innocent.

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DISCUSSION

DR. HENRY A. DAVIDSON (Flemington, N. J.).—It is refreshing to hear a paper that, for once, concentrates on the examination of the complainant rather than of the defendant. Certainly as much psychopathy may lie within the minds of the accusers as of the accused. Dr. Orenstein has given a credible dynamic explanation for 3 cases of false accusation. One need not be an analyst to accept his interpretation of the motives. Some of us will be satisfied with even more homely explanations. In the first 2 cases, at least, the accusations served to get the accusers off a hook. For any unmarried girl a charge of rape is more face-saving than a confession of cooperative fornication.

It is easy to understand why a high proportion of sex complaints are rooted in fantasy. I hope that some student of the subject, springboarding from this pioneer paper, will make a study of the psychopathology of accusation in other areas of crime. It should include fantasy-motivated charges of theft, murder, perhaps even treason, too. It might include an inquiry into the pathology of the accusing apostate: the unfrocked priest, for example, who dedicates himself to fantastic accusations against his former church; or the reformed communist who feels an exhibitionistic compulsion to accuse his former fellow-conspirators, and so on through the dismal parade of renegades and turncoats who seem to earn solace only by slander. Dr. Orenstein's paper has, for me at least, opened this door into a new aspect of psychopathology. On a humbler plane, but still worthy of psychiatric interest, are such phenomena as the former VA or army doctor who yields to a strange impulse to write weird exposés of medical malfeasance in his former agency. Indeed this is not too far removed from the physician who, in a mixed meeting, buys an inexpensive spot in the limelight by hurling calumnies at the entire medical profession.

In American annals, surely the best known of the neurotically induced accusations was the Salem witch hunt of 1692. A bevy of 17th century bobby-soxers caused 20 women to be hanged as witches. Long after this hysteria had ebbed, one of the accusers, then in a fatal illness, cried that she did not want to die with any sin unrepented. But, she was

told, there was one sin that even the merciful God would not pardon. It was not a violation of such canons as "thou shalt not steal" or "thou shalt not commit murder." Breaches of even these injunctions might be pardoned, said the pastor. But the unforgivable sin was a violation of the commandment: "thou shalt not bear false witness."

The psychiatrist, when he examines the defendant, cannot—indeed, must not—mete out the measure of guilt. But properly oriented, he can help the administration of justice as the court's most effective lie detector. If he but thinks of it, he can render an immense service by recognizing the unfortunate character whose inner needs have compelled him to bear false witness against his neighbor.

DELIRIUM: A GAP IN PSYCHIATRIC TEACHING

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Delirium would seem to be the forgotten chapter of psychiatry, for it gets less attention than any other major psychosis. This neglect is the more surprising when one considers that our children learn about delirium, if only to know it by name, long before they ever hear of the other psychoses. It is the exceptional lad of 14 who has not already added the word to his vocabulary.

Indifference to delirium, or unawareness of it, may be seen in several articles that will presently be cited. They are all by competent neuropsychiatrists, and have appeared in our better journals.. They all contain case presentations of delirium, meticulously reported, yet nowhere are these spoken of as cases of delirium. Indeed in some of the articles the word is not even mentioned.

Olkon(1) reported the case of a man with subdural hematoma. Shortly before admission to hospital the patient "became confused, completely disoriented as to time, place and person, failed to recognize his wife and immediate family, and became violent. He refused food and water for fear it was poisoned, and [thought] people were standing over him with guns to kill him." On examination he was "confused, apprehensive and irrational. He did not know his age or where he was, and did not recognize his family." On evacuation of the hematoma he got well.

Frugoni and Walsh(2) reported the case of a man who shortly before admission had become "irrational and disoriented." In hospital he "mumbled unintelligible words and phrases to himself. . . . . He complained of auditory and visual hallucinations and was disoriented for time and place." There were neurological and chemical signs of bromide intoxication. He recovered promptly.

Bucy, Weaver, and Camp(3) reported an unusual case of bromide intoxication that after many years "culminated in a state of complete mental confusion, amnesia, disorientation and hallucinosis." On examination the patient was "completely disoriented in all spheres," and there were fearful hallucinations of fish, snakes on the ceiling, and "his mother-in-law peeking over the transom." The serum was high in bromide. The acute symptoms cleared up.

The 3 articles cited all deal with cases of delirium, but not even once does this word appear in any of them. Olkon speaks of his case as one of "subdural hematoma with acute psychotic manifestations." Frugoni and Walsh often speak of "bromide psychosis," never of "bromide delirium." Bucy, Weaver, and Camp burden themselves to say that the bromide intoxication "culminated in a state of complete mental confusion, amnesia, disorientation and hallucinosis" when they could have said "culminated in severe delirium."

These three articles are reports of single cases. The next 2 are longer articles on the psychiatric aspects of bromide intoxication.

Kitching(4) wrote on "Mental Symptoms in Bromide Intoxication," giving a valuable review of the subject illustrated with 9 case reports, of which the first 8 are cases of bromide delirium. But not once does the author use the phrase "bromide delirium." Indeed only once does he use the word "delirium" or its derivative, and that is when he makes a passing reference to a patient's "delirious state." In his general discussion of the subject he emphasizes the frequency in bromide intoxication of "a state of confusion, with clouding of consciousness"; "delirium" would say it quicker and better!

The final article, by Angyal(5), is a 24-page discussion of bromide intoxication as seen in a psychiatric hospital, with 21 case reports. The great majority are cases of bromide delirium, but not once does this phrase appear in the article. The word "delirium" or "delirious" appears just 5 times (not counting several instances when "delirium tremens" is mentioned in the past history of some patients who had been alcoholic, and once when the word appears in quotation from another author). Never does "delirium" appear in discussion of any of the case reports. Time after time the

author speaks of a bromide *psychosis,* or a bromide *intoxication.* In his Case 15—that of a woman who passed through a severe delirium in which she was disoriented, confused, incontinent and thought the water was poisoned—the illness is summed up as a "bromide *episode.*"

Let it not be thought that bromide psychosis, bromide intoxication, and bromide delirium are synonymous. A man may have bromide intoxication without being psychotic; and he may have a bromide psychosis without being delirious(6).

This paper is a plea to stop looking upon delirium as something esoteric. In general hospitals, in the days when infections ran wild, delirium was—and probably still is—the commonest of all major psychoses. In mental hospitals, though it is not as common as schizophrenia, it is far from rare, even if, as the citations show, it is more often seen than recognized. A psychosis known by name to every literate layman belongs in the working vocabulary of psychiatrists.

Definition of Delirium

Every delirious patient is disoriented (though, as will be seen presently, not everyone who is disoriented is delirious). The delirious patient in addition is apt to be dull, sluggish, restless, inattentive, fearful, excited and disturbed by nightmare-like fancies and hallucinations. These symptoms may shift rapidly and may even go away for a time, so that lucid intervals are common. In many cases the symptoms are worse at night, and sleep is disturbed.

Partial or Incomplete Delirium.—Delirium may set in suddenly, the full-blown picture developing in an hour or two. But it may also set in gradually, in which case disorientation is likely to appear first in the sphere of time. Then, if the delirium waxes, disorientation will show up in the spheres of place and person. Conversely, as delirium wanes, the patient tends to become clear first as to place and person, and last as to time. Thus it is seen that orientation for time is more vulnerable than that for place and person. This is because orientation for time is a highly complex function, dealing as it does with abstract notions of time. Children pick up concepts of place and person—"Mother," "my house," "Jimmy's house"—long before they acquire the abstract concepts that deal with time(7).

Irreversible Delirium.—The impression has prevailed that delirium is always of toxic origin and always reversible. This is incorrect. In some cases of organic dementia, notably in senile dementia and dementia paralytica, the patient, if he lives long enough, may wind up in a delirium even when there has been no toxemia. This delirium may last for months or even years, and is irreversible(8). That which occurs in senile dementia is termed "senile delirium"; that in dementia paralytica, "paralytic delirium." In the classification of psychoses of The American Psychiatric Association, "senile psychosis, delirious and confused type" is senile delirium. With progressive growth of our ability to ward off and cure intercurrent infections, we may expect to see more and more of these cases of senile delirium.

In the terminal delirium of the organic dementias the patient is disoriented, as in any toxic delirium. There may be some differences, notably in the field of affect, fear being more pronounced in toxic delirium. I have seen cases of senile delirium in which the patient was disoriented for a year or more without ever being afraid. But the differences between toxic delirium and that of the organic dementias have not yet been adequately studied.

A problem of terminology arises. One would like to speak of "toxic delirium" and "organic delirium," the latter referring to the terminal nontoxic deliria of organic brain disease. The trouble is, though, that the inference might be drawn that one regards toxic delirium as not organic but "functional," which of course it is not.

Some Differences Between Delirium and Schizophrenia

Delirium and schizophrenia have certain features in common. However, there are also many differences, three of which will now be considered.

(1) The delirious patient is disoriented; the schizophrenic (except as will be shown below) is not.

(2) The schizophrenic tends to be aloof, unfriendly; his "rapport" is deficient. The delirious man, in contrast, is in good rapport. He is cooperative, and, far from being aloof, may cling to the physician for reassurance, like a frightened child to its mother.

(3) Though hallucinations and delusions occur in both disorders, they differ in the degree of self-reference which they reveal (9). Self-reference is elevated in schizophrenia but not in delirium. The schizophrenic sees himself threatened as an *individual;* he is singled out for abuse; he stands isolated. The delirious man, in contrast, is apt to imagine dangers and threats that menace not him alone, but a group to which he belongs. Thus, when he thinks the house is on fire, the danger threatens not only him but many others as well. A World War I veteran in a fever delirium thought German soldiers were trying to storm the house, which, if true, would have imperiled all within and not just him alone.

The foregoing differential points apply to delirious patients who are not also schizophrenic. Schizophrenics may become delirious like anyone else—for example, if they take too much bromide—in which case the differential points do not apply. The aloof schizophrenic is likely to remain aloof when he becomes delirious.

Delirious Disorientation and Paranoid Disorientation

The average schizophrenic is well oriented. A man may have a severe schizophrenia for 30 years, yet orientation for time, place, and person will be flawless. But a small number of schizophrenics *do* show disorientation—and I don't mean those who develop toxic delirium as a complication. This disorientation arises when false ideas in respect of place and person (less often, time) are woven into a delusional system. Such "paranoid disorientation," as it may be called, differs in 2 respects from delirious disorientation.

(1) The delirious man tends to mistake the unfamiliar for the familiar. In hospital he thinks he is at home; the nurse he mistakes for his wife, the fellow patients for members of his family. The mistakes of a delirious man have a homely flavor, as in the case of a farmer in hospital who mistook the sound of a scratchy gramophone for the crowing of a rooster. The man with paranoid disorientation reacts quite the opposite. His mistakes, far from revealing a homely trend, bear the stamp of the remote, the unfamiliar, the exotic, the bizarre. A schizophrenic who has never been more than a few miles from home may develop the delusion that this is China or Ethiopia. Delirious patients have often mistaken me for a son or brother or friend, but it was a schizophrenic who identified me as Chancellor Dollfuss (in the days when Dollfuss was in the news).

The tendency in delirium to mistake the unfamiliar for the familiar was observed and reported by Hughlings Jackson, whose explanation of this phenomenon is in my opinion a work of genius(10). The phenomenon results from paralysis of the highest cerebral centers. We habitually think in terms of what we know, of what we have experienced over and over again, of what is familiar. When we are confronted with a novel situation, the simplest reaction is—not recognizing the novelty—to identify it as something we are already familiar with, like the child who thought the Lord's Prayer begins, "Our Father who art in Heaven, Harold by Thy name." Recognition of novelty requires an act of discrimination, a complex task performed by the highest cerebral centers. When a delirious man mistakes hospital for home and nurse for wife, he is in error, but his mistakes are not as farfetched as they might seem. Being befuddled, he has failed to grasp a novel situation as something new and unfamiliar, and has identified it as something old and familiar. His mistakes are those we all make when we are exhausted or sleepy—greatly magnified, of course.

The mistaking of unfamiliar for familiar is illustrated by two unforgettable examples.

Hughlings Jackson cited the following case(11): "A sack dealer was delirious during erysipelas. The house-surgeon opened a small abscess in one eyelid while the patient was in a strait-jacket. The patient's account of these circumstances was that he had been to a public-house, that the landlord fastened him down with two sacks, and then poked out one eye."

To a man who probably was no stranger

to the pubs in his neighborhood, and indeed to any man, there is a homely quality in the notion of having gotten mixed up in a barroom brawl where you were poked in the eye. To be sure, it's not the sort of thing that happens every day, but still it's an event couched in terms of daily life. In contrast, the notion of a surgeon lancing an abscess in your eye borders on the remote, almost the fantastic, and you have to be clear-minded to be able to grasp it.

The other example is taken from a case report by Weisenburg(12). The patient had a brain tumor and was delirious, and, according to Weisenburg, "when he was first examined by me, he thought he was coming to have a hat fitted." The patient thus had a dim realization that he was having his head examined. To have your head examined is an unfamiliar experience, something out of the common. The delirious man couldn't grasp it, and instead he saw in it the familiar experience of being fitted with a hat.

In sharp contrast is the case of a schizophrenic who, during a bromide delirium, named the place (the Harrisburg State Hospital) as "China or Japan"(10). (This was in 1936, before China and Japan came to occupy the place in our thoughts they did later.) On emerging from the delirium he remembered having made this remark and recalled what had prompted it: he had seen a ward attendant putting shoes on a fellow patient, who made a wry face, as if the shoes pinched, and this made him think of China, where feet are bound tight. Now while this example is taken from a bromide delirium, there was schizophrenia underlying it, and the example is an illustration of paranoid rather than delirious disorientation. It shows the far-fetched reasoning of the schizophrenic, the identification in terms of the remote and the bizarre. A delirious man who was not at the same time schizophrenic might, in analogy with Weisenburg's patient, have thought he was in a shoe store watching a fellow customer being fitted.

The delirious man tends to think and act in accordance with the patterns of lifelong habit. A man in delirium tremens, when I walked into his room in the hospital, mistook me for a friend and proceeded to play the rôle of a courteous host: he invited me to sit down and said he would try to find me something to drink. The classical "occupational delirium" is a common illustration of this tendency.

(2) The delirious man, when he misidentifies the place, etc., does not know he is mistaken, whereas the man with paranoid disorientation in most cases knows very well that you consider him in error (or at any rate that you *profess* to). When the delirious man in hospital says he is at home, he will be surprised should you tell him you think otherwise. He will be embarrassed and apologetic, and should you undertake to set him straight he will try to remember what you tell him. In contrast, the paranoid man knows that when he says this is Alaska you don't agree with him. As a rule he believes *he* is right, not you, and he thinks you secretly know him to be right but for special reasons profess to hold him wrong (*e.g.*, you may be testing his mind). While technically he is disoriented (since he gives incorrect answers to questions as to place, etc.), his disorientation is not of a piece with that of delirium; it rather is part of a delusional structure.

Is It Safe to Withdraw the Drug Responsible for a Drug Delirium?

The causes and treatment of delirium will not be taken up in this paper, except for the question posed in the heading. At one time it was believed by many that the abrupt withdrawal of drugs, and especially of alcohol, favors the onset of delirium, and while this view has lost some of its popularity, it has not been discarded as it should be. Two groups of cases seem to support the view, but as I shall try to show, the support they lend is deceptive and fallacious.

The first group consists of cases in which the onset of delirium follows soon after withdrawal of the causative drug. Such cases, however, reveal the play of many other factors beside withdrawal. A common example occurs in one of our states where it is routine procedure to send alcoholics and psychotics to jail for safekeeping

pending commitment to hospital. The following case is typical.

A man on the verge of delirium tremens was put in jail, where he was given no alcohol, and 2 days later was found in severe delirium. How tempting it is to conclude that the abrupt withdrawal of alcohol, in a man accustomed to his daily quart of whiskey, precipitated the delirium! But the seemingly obvious may harbor many a pitfall. Here is what happened. The man had a severe gastritis, that distressing forerunner of delirium tremens, and had reached the point where he was vomiting even the softest food. In jail he was fed like any prisoner, with a menu of pork sausage, fried ham, and greasy potatoes—food that even a healthy man sometimes can hardly stomach. He ate virtually nothing. Moreover, he was given no fluids, and his dehydration, already bad at home, grew rapidly worse. On the verge of delirium tremens, he passed his nights in terror, but was not given paraldehyde and got literally no sleep. Thus for several days this sick man got virtually no rest, no food, and no fluid, and his meagre resources were exhausted. It was this exhaustion, not the withdrawal of alcohol, that brought the delirium into actuality.

The second group consists of cases in which the delirium has already started prior to withdrawal of the drug, and seems to get worse afterward.

For example, a man in bromide delirium is brought to the hospital in a state bordering on coma. He is in a "low muttering delirium" and is helpless in bed. Bromide is stopped, and on the third day a panicky man flees down the ward corridor in his hospital gown, upsets the nurse's medicine tray and is barely restrained from climbing out the window. The ward physician duly notes for the record that the patient today is "much worse," and wonders if the withdrawal of bromide might not have been too abrupt. Nothing could be more fallacious. The patient has become excited and violent on the third day, not because he is worse, *but because he is better.* On admission, when he was almost in coma, his highest cerebral centers were almost completely paralysed. He didn't have the power to be violent. In the course of recovery the various "levels" of the highest centers are not likely to recover at a uniform rate; the lower levels, being simpler, are able to recover faster, while the higher ones, being much more complex, need more time. Thus the patient, on the third day, has reached the point where the lower levels are no longer paralysed; and, from continuing paralysis of higher levels, the lower ones are permitted to function without check, and so there is excitement. From the standpoint of a policeman the patient is worse, for he now threatens the peace, where 2 days ago he lay meekly in bed. But from the standpoint of physiology he has made a great stride toward restitution(13).

It is doubtful if it ever does any good to continue a drug responsible for a delirium; discontinuance would seem much the better course. It is also unwise to use, in treatment, any drug that itself can cause delirium. The use of bromides and barbiturates in delirium tremens is foolhardy; paraldehyde is the only hypnotic to use in such cases.

Excellent articles on the treatment of delirium have appeared in recent years, notably those of Robinson(14), Fantus and Kraines (15), and Doty(16). Wolff and Curran(17) have contributed a valuable and detailed analysis of the symptoms found in 106 cases of delirium and allied states. Of particular value is their study of delirious content in the light of the patient's prepsychotic personality problems.

Summary

Delirium is a psychosis characterized (always) by disorientation, and (commonly) by restlessness, dullness, fear, hallucinations, and other mental symptoms. It is often, but not always, due to toxemia, clearing up when the toxemia has been corrected. It may also occur as a terminal event in the course of an organic dementia even when there has been no toxemia; in such cases it may go on for months and years, and is irreversible.

The disorientation of delirium differs in nature from that seen occasionally in paranoid schizophrenia. The delirious man, unlike the schizophrenic, tends to mistake the unfamiliar for the familiar (mistaking, for example, hospital for home, and nurse for wife). His thoughts and actions follow the patterns of lifelong habit—something that applies to healthy people too. The difference is that the healthy man, with highest cerebral centers in good condition, is able to discern when a situation calls for a response out of the common groove. The delirious man, in contrast, has, from paralysis of the highest cerebral centers, lost this power of discrimination, and responds with habitual patterns of thought and action when they are no longer appropriate.

In drug delirium it is advisable to discontinue the causative drug abruptly and completely. In the treatment of delirium it is unwise to use any drug that can itself cause delirium. Bromides and barbiturates are especially to be shunned.

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MODERN PSYCHIATRIC NURSING[1]

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Crossing a frontier, whether it is the boundary line of a nation or whether it leads to new and uncharted areas of experience and of thinking, involves one in many adjustments. Today, there are new boundary lines confronting the nursing profession especially in psychiatric nursing; the road to good mental health is frequently not clearly visible. There are but few scientific studies in psychiatric nursing upon which we can adequately base our decisions for action. Although there has always been a recognition of mental disorders, when one reviews the history of medicine it is evident that the emphasis has been placed on physical disability from the standpoint of pain and discomfort that is expressed through structural and functional changes rather than emotional disability. Signs and symptoms that can be observed and clearly described are plentiful and, although general literature abounds with descriptions of emotion, it is literally crossing a new frontier to find descriptions of emotional disorders in a medical or nursing textbook. It is the fortunate administrator of a hospital for the mentally ill who is able to employ even an average of one professional nurse for 150 patients. There are hospitals without nurses and many with only a few. It is practically a phenomenon to find a professional nurse nursing the mentally ill as a therapist on the psychiatric team.

It is interesting to note that in 1949 The American Psychiatric Association awarded to 3 hospitals the National Mental Health Achievement Award. One of these hospitals was the Veterans Hospital of North Little Rock, Arkansas, which gained the recognition for its Community Plan. This plan of patient care embraces the facilities of the entire community and invites the community to participate in the rehabilitation of the patients. This is a new step in psychiatry. Formerly, the community placed the mental hospital on the outskirts of the city and guards were posted at the gates of the hospital grounds. Today, the public is being invited into the hospital for the express purpose that they may become acquainted with and assist in solving the complex problem of good health in the care and prevention of mental illness.

More and more we are being convinced that many of the so-called medical and surgical ills of today spring from unrecognized emotional needs or undesirable adjustment to social living. Every day the modern nurse is faced with her own and her patients' emotional needs and their effects. Every day in the general hospital or in the home or schoolroom, she comes in contact with psychosomatic (really psychiatric) problems; she deals with character disturbances and emotional illnesses. Until the nurse is prepared through actual experience in a learning situation under proper supervision, she will not understand what all this chaotic jumble of behavior means and how deeply it influences the course of physical illness. Unless graduate nurses are encouraged to supplement their basic program and the schools of nursing include such learning-experience for the student body in the basic professional curriculum, nursing will be done blindly and intuitively, sometimes doing more harm than good.

When we speak of good health today, we mean the harmonious functioning of the body and the mind that makes for clear logical thinking and performance. It means satisfied and symmetrical living. It means health—total health. Therefore, a nurse today should be able to function in her profession as a healthy person endeavoring to cooperate in restoring health, mental and physical and spiritual, to the individual and to the community.

There is a growing realization that psychiatric nursing is not a particular nursing specialty. It is not a separate and exclusive

[1] From the Veterans Administration Hospital.

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type of nursing activity in which only highly skilled professional nurses may practice. Psychiatric nursing invades all fields of nursing and indeed permeates the entire life of the modern nurse. Modern psychiatric nursing is moving out from the public and private mental hospitals into the general hospitals to the bedside of the patient. It is being taken into the home by the public health nurse and into the factory by the industrial nurse. It finds its way into the schoolroom through the school nurse and is made available for all those who need such care and assistance through the services of the various clinics established for that purpose.

The nurse who understands how emotions influence the activities and responses of her patient and herself will not be too disturbed over a patient's untoward behavior, uncooperativeness, and attention demanding. She will understand that no abnormal behavior or emotional disturbance is illogical, incomprehensible, or without meaning. She is aware that all abnormal behavior and emotional disturbances are related in one way or another to that all-powerful, all-impelling emotion, *fear*—fear of the unknown, insecurity.

The nurse sees in the mentally ill patient the result of poor mental hygiene, emotional insecurity, the human wreckage that might be salvaged through enough and the right kind of medical and nursing care. After suitable hospital care some patients will return to their homes; some will never return. Many, it is true, will be rehabilitated; some will be able to live a rather happy life under proper supervision. The public as a whole does not realize the amount of nursing energy necessary to keep these patients from regressing. It is the function of the psychiatric nurse to endeavor to assist the patient to develop and practice desirable mental hygiene habits so that he may find satisfaction in living even though it must be under the supervision of institutional regulations. This if done properly takes an enormous amount of skill and energy on the part of the good nurse. She also endeavors to interest him in cooperating in his treatment through creating interest in what is happening. Under the guidance of the physician she interprets to him the type of treatment he is receiving and how he can cooperate in order to make that treatment more effective.

The sad part of this story is that relatively few nurses are adequately prepared to practice psychiatric nursing and to cooperate in community planning. The American Medical Association recommends that psychiatric learning-experience for the medical student be incorporated into each semester's program of study. Is it not just as important for the professional nurse? During the past few years psychiatric experience has been considered an essential part of the basic professional nursing curriculum by far-sighted leaders. The pity is that, even when the faculties of schools of nursing are convinced that this experience is an essential learning need for the young nurse, desirable affiliations that meet the criteria for good learning-experience are extremely difficult to obtain. It is a vicious circle: until nurses are prepared to function in desirable learning-experience situations as teachers and supervisors, we cannot expect to meet the need of the public for nurses who have insight into behavior and for modern psychiatric nurse specialists.

According to the information discussed at the Mental Hospital Institute of The American Psychiatric Association, Philadelphia, Pa., April, 1949, the hospital personnel standards for the care of the mentally ill are far below that which is needed:

	Recommended standards	Present personnel
Psychiatrists	1-30 pts.	1-255 pts.
Professional nurses ..	1-4 "	1-152 "
Trained attendants ..	1-6 "	1-16 "

The estimated shortage of professional workers in psychiatric hospitals is:

Psychiatrists	10,000 to 14,000
Clinical psychologists	1,700
Psychiatric social workers....	4,000
Psychiatric nurse specialists..	15,000

In 1946, Mrs. Laura Fitzsimmons after completing her survey for The American Psychiatric Association stated that 47,000 additional nurses were needed in psychiatric nursing.

I bring this information to you so that you may know the need for nurses and other

professional workers of the psychiatric team; it is not only the nursing profession that falls short in producing workers. It is obvious that unless the psychiatric team is complete and adequate the professional nurse is handicapped in her effort to demonstrate nursing care.

Esther Lucile Brown says, "The nursing profession will make its best contribution only when it is organized to work with the public and to find its place in the team of allied professional groups." This is especially true of modern psychiatric nursing. In the psychiatric hospital and in the mental hygiene clinic, the nurse must synchronize her work and accomplishments with those of the rest of the team—public health nurses, psychologists, social workers, as well as the physician leaders. Dr. Holister, regional consultant for the U. S. Public Health Service, speaking before a group of nurses, social workers, and psychiatrists, said, "Mental hygiene must permeate into the schoolroom so that even the school teacher may become a part of the psychiatric team."

So you see the work of the team in hospital or clinic becomes community-wide. It embraces and invites the cooperation of all those who might contribute toward the rehabilitation of the patient or the prevention of an emotional crisis. The work of the psychiatric nurse then becomes broadened and deeper in scope. In the past her work with the patient involved the doctor and the psychiatric aides or attendants. Today, the doctor becomes the leader of a group of workers, each a specialist in his own field, and the function of the nurse as one of these workers is to aid him in the coordination and synchronization of the contribution of each of the other workers on the team.

What then is the unique contribution of the nurse to the patient as a member of this team? The patient looks to the nurse for help and guidance. He does not understand why so many persons must ask him so many questions; he depends on the nurse to interpret to him what is expected of him, how he should act, and at the same time he expects of her the firm, objective yet loving care of a friend. In a psychological sense she often plays the rôle of a mother and it is important that she function as a good mother. This is truly nurse-patient relationship and is the quality of professional nursing psychiatrists are anxious to work with and the public is willing to pay for. One cannot expect personal satisfaction nor the monetary compensation of a professional worker for performing nursing activities that can be performed equally well by less skilled workers.

How then can we prepare the future nurse for such a rôle on the nursing team and still be able to give to the public, the patient, and the doctor the service they expect? We cannot refuse to admit that the head nurse and instructor in the schools of nursing must understand and be able to practice the principles of psychiatric nursing so that the student can observe good mental hygiene at work. She must be taught to put into effect the principles of psychiatry no matter what type of medical care the patient is having prescribed. Therefore, student preparation for the affiliation in psychiatric nursing should begin early in the educational program through proper guidance and direction by the instructor and through proper assistance in self-evaluation done periodically. The principles of psychiatry should be interwoven in nursing arts, sociology, psychology, anatomy, and physiology. It is no longer an isolated subject.

It is important that the student nurse be placed in a learning situation where she may observe the nursing team working harmoniously and productively for total health. It is important she learn to put into practice the principles of good nursing, which will include the recognition of the term "health" to refer to a total being, body and soul, that functions as one unit directed by a coordinating healthy mind. It is important that she learn to recognize her own responsibility to function as one unit made up of parts operating in a harmonious pattern that will contribute impetus and strength to the team of professional workers. She should learn to know herself, including her weaknesses and strengths, which she should utilize for the welfare of patients. The patient may draw courage from the observation of her power for unity of thought and action, and her ability to cooperate with others.

The amount of understanding and insight, of acceptance and forbearance, that the nurse shows in handling her own emotions and

her patients' emotions, spells the difference between just a nurse and a good nurse. She must learn to recognize the significance of her own behavior and that of others so that the desired results may come from the efforts of the working team. She must learn to control her personal emotions so that they do not interfere with the therapy that is being prescribed for the patients. Her personal satisfaction should come from the fact that she has helped many, and not just a few patients who have been pleasant to work with. The criteria of ability to give good nursing care should lie in the ability to care for the most difficult patients as well as to work harmoniously with exacting members of any therapeutic team. This type of professional nursing can be developed only through guided practice of the student and must be initiated as has been stated, at the beginning of the professional program of the school of nursing if not sooner, and carried forward each day. The affiliation in psychiatric nursing should be prepared for in such a manner that the student will receive maximum benefit from the experience. It is not a separate part of her learning but the climax of a learning opportunity that unifies and integrates learning that will produce an expert nurse.

The selection of the hospital and clinic for the psychiatric experience is important as a part of the faculty responsibility. Desired learning will not take place unless the proper concepts are demonstrated before the student so that she might have the opportunity to practice and evaluate for herself and decide for herself what she feels is good nursing. The aptitude might be present in the student; however, the motivation to establish desirable patterns of behavior in person-to-person relationships, and to assist in the rehabilitation of the mentally ill, must come from a deep desire of the nurse because she sees in it good things for herself and for her patients.

Let us now turn to the psychiatric nurse specialist. Modern psychiatric nursing is fast becoming an envied field. Reversing the picture of a few years past, patients are being discharged from the modern psychiatric hospital and referred to clinics as quickly as families and communities can be prepared to accept them. They are being rehabilitated either in their own homes or in foster homes in the community of their choice. One of these patients may find it desirable to spend some part of the year in the hospital, and the rest of the time can be spent in his own home where he can participate fully or partially according to his ability, in family and community life. Thus the modern psychiatric nurse specialist, whether in clinic or hospital, finds that she plays a rôle in the life of the patient over a period of months or even years. She becomes the patient's friend and his family's friend. She may work with the family along with the psychiatric social worker under the direction of the doctor as his assistant and in doing so finds that she becomes a part of the community and her interests are many and varied. The hospital patients are often referred to the mental health clinics whose function is to keep the patient ambulatory and functioning in the home as long as possible for more meaningful living. It is true that psychiatric care takes a long time, sometimes years. Adults resist change in standards of thought and behavior and take on new ways slowly. Some patients cannot hope to be as well again as they were before. However, much can be done. In the hospitals the nurse functions as a specialist either as a staff nurse or as head nurse who helps to provide for the total welfare of the entire unit or group of patients. She assists as a therapist on the team through an active participation in the psychotherapy prescribed for the patient. She must read, and read some more; she must think about the kind of reading she does and put aside her prejudices and become thoroughly interested in people, notice their reactions, their joys and sorrows, their interests and dislikes. She must become keenly aware of what constitutes an emotion, including the symptoms that lead up to the expression of an emotion and how that emotion is controlled, feebly though it may be, by the patient. Does he make a struggle to control the emotion or does he passively drift along with the tide?

Modern psychiatric treatment demands of the nurse a broad understanding of physiology, anatomy, and cultural anthropology as well as a foundation in chemistry and

other physical sciences so that she can participate in such treatments as electric and insulin shock therapy. There is much the nurse can contribute toward patient care in understanding the principles of hydrotherapy, occupational therapy, and physical therapy. One of the important needs of the psychiatric nurse today is to be able to understand the principles of and to participate in play and recreation. This particular function seems to be one of the most difficult areas in the learning and experiencing program of the psychiatric nurse, and is all too infrequently understood by the student nurse. A sound philosophy and religious understanding is also needed along with a knowledge of teaching and learning for the purpose of assisting with or conducting psychotherapy groups or individual psychotherapy under the general direction of the physician.

The medical care of the psychiatric patient is prescribed by the physician in the clinic, or perhaps in the case of the psychiatric hospital the patient may be diagnosed and the treatment outlined by a group of doctors, nurses, and other workers of the psychiatric team. This particular type of diagnosis and treatment makes its demands on the psychiatric nurse. She is expected to be verbal and express her opinion about the patient. It follows that she should have a broad understanding of the patients' needs through reading, observation, and experience. This emphasizes the need for the development of self-direction and frequent attendance at seminars and workshops for the purpose of broadening her background for productive patient care. Such a professional nurse will be interested in research, for she will be constantly looking for ways and means of improving her services to the patient and of promoting better community health in general.

The nurse must understand the essential nature of psychotherapy so that she can apply its principles to nursing day in and day out. She will then be able to give to the patients firm, logical, understanding guidance, which they require. They need warm, gentle assurance that no blunder may be made in handling their particular personal problem; they want the nurse's sympathetic but not maudlin friendship.

Surgical nursing of the psychiatric patient is a specialty in itself. Besides the common surgical conditions that exist in any group of patients such as appendectomy, tonsillectomy, etc., surgical procedures such as lobotomies and leucotomies are not uncommon. The skill and techniques of nursing for such patients must be highly developed in order that the patient may receive maximum benefits. Plastic surgery is also frequently performed and expert nursing is a necessity for successful outcome. This type of nursing care requires skill at any time, but with the added problems of personal maladjustment and the irrational attitudes often associated with such procedures, success becomes a real victory.

To conclude, we can readily agree that in order to practice modern psychiatric nursing the following principles apply: (1) All nurses should be prepared to understand and practice mental health in their personal and professional relationships. (2) Preparation for the clinical practice in psychiatry should be begun early in the basic professional program. (3) Student nurses should have the opportunity of an adequate period of clinical practice in psychiatric hospitals, clinics, or other agencies in order to develop desirable attitudes and habits for total nursing care. (4) All professional nurses who have not had psychiatric experience should have and should be able to avail themselves of the opportunity to develop the necessary skills for practicing psychiatric nursing in caring for all patients through supplementary courses and experience. (5) The nursing profession should take upon itself the responsibility of adequately meeting the needs of those who utilize or should utilize the services of nurses for maintaining or reestablishing mental health. (6) The nursing profession should endeavor to interest an adequate number of promising professional nurses to prepare themselves in advanced psychiatric nursing to meet the present and future needs for nursing specialist and consultants.

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THE INHIBITION OF BEHAVIOR: WORKING CONCEPTS

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Inhibition of action tendencies that threaten to disrupt the ongoing pattern of the individual's behavior is a means that we employ most extensively in the continual maintaining of our optimum effectiveness. A major part of the work of the psychotherapist is concerned with defects in this procedure. Common illustrations are the efforts of the therapist to enable the passive patient to free himself from excessive use of inhibition in dealing with his resentments and hostilities, or to enable the panicky patient to relax his inhibitory defenses so that he may recognize and start to deal with his latent homosexuality.

Some definition of terms is required at this point. By intensified action tendency is meant an urge to act that has acquired a degree of intensity that gives it precedence over the ordinary minute-to-minute reactions of the individual. The term covers not only those urges to act that find explicit manifestation but also those that remain implicit and that we designate as ideas, concepts, and attitudes.

Though the achieving of acceptable expression for intensified action tendencies that have been inhibited constitutes a major part of the work of the therapist, considerable disagreement exists as to how this should be done and as to how the results attained are brought about.

Several workers have commented upon the fact that remedial effects have been produced by quite diverse and, at least superficially, contradictory psychotherapeutic procedures carried out upon what seem to be similar cases (Rosenzweig, 1936; Mowrer, 1948; Shoben, 1949; Ziskind, 1949).

This paper is concerned primarily with the nature of the forces that prevent action tendencies from achieving expression either in reality, in daytime fantasy, or in dreams. It is desirable that these forces should be described in terms suited to the experimental method since many of the existing concepts are allegorical or anthropomorphic to a degree that sets them entirely apart from the existing current of experimental social science.

Many terms have been employed to designate these forces, those in most common use being "suppression" and "repression." We have avoided them for two reasons: first, because they form part of a theoretic system, much of which we consider to be of limited effectiveness; and second, because of what is stated above, namely, the desirability of using concepts operable both in the experimental social science laboratories and in the field of clinical investigation. Clearly, such terms as "dissociation," "concentration," and "attention" are closely related members of this family of concepts, which we propose to discuss under the name of inhibition, and, indeed, on some occasions appear to act as identical twins.

Inhibition designates a range of activities that can be placed on a continuum. At one end there is the automatic, but easily reversed, exclusion of action tendencies that might interfere with our dealing most effectively with the matter in hand, *e.g.*, our elimination of response to street noises when we are reading a letter. Further along the continuum, we reach a point where this superficial, automatic device is not sufficient, and the efforts that are made to reinforce it themselves achieve expression—*e.g.*, we become aware of our special efforts to "put out of our minds" our son's threatened pneumonia while we dictate the morning mail. Finally, there is the automatic, relatively irreversible, exclusion of those action tendencies—*e.g.*, latent homosexuality—that are likely to disrupt not simply a particular activity, but any ongoing activity, since they constitute a serious threat to the image that we have of ourselves.

The forces that act at these various points to bring about limitation of activity are multiple, and the variables that affect each of them are also numerous. The forces identified thus far are the following:

1. Action tendencies that are being expressed (ongoing activities) inhibit, in varying degree, all other action tendencies.

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2. Where the ongoing activity is insufficient to inhibit other action tendencies, and where the goal is, nevertheless, important to the individual, he may begin to respond to additional motivations—prestige, competition, need for acceptance—and thus the ongoing activity may develop sufficient intensification to maintain itself against the pressure of other action tendencies.

3. Long-term, well-established action tendencies, especially those derived from cultural indoctrination (*e.g.*, avoidance of incestuous interest in one's sister) or from urgent personal need (*e.g.*, passivity with respect to a domineering father), continuously inhibit all action tendencies that might interfere with them.

4. All intensified action tendencies show a trend toward expression in reality, fantasy, or daydreaming. Clearly this is not an inhibitory force in the sense of the three that we have just described, but it is a major reason for their existence (among other reasons being the unending reactivity of the organism to its environment and the need to preserve goal-directed behavior).

It will be noted that these forces frequently will be in opposition to each other, hence any given limitation of behavior is a resultant.

We propose to examine certain of the variables that affect each of these fundamental forces.

1. In regard to the first, namely, the inhibitory effects exercised by ongoing activity over other action tendencies, we may say:

(a) The more the ongoing activity is intensified, the greater will be its inhibitory effects. Where the individual is deeply interested or intensely concerned about a matter, the less likely it is that other action tendencies will succeed in gaining expression. This is true of all three points in the continuum of inhibition that we have described.

(b) As a derivative of this, one may say that where that ongoing activity is with respect to a matter external to the individual —*e.g.*, watching a show or going up a ski-tow —inhibition of such internalized activities as rumination over masturbation guilt will be the more complete. Hence, too, are derived some of the values of recreational and occupational therapy, the values of continuing the psychoneurotic patient in work while his treatment is going on, and the value of the early work rehabilitation of all patients.

(c) A second derivative is that where the ongoing activity is predominantly implicit—*e.g.*, in depressive ruminations—reactions to external situations will be inhibited. Hence the complaints by such patients regarding their attention, concentration, and memory. Hence too, probably, the complaints of confusion and distortion of reality (delusions) found in depressive and anxious patients. These appear to result from limitation of the field to which the patient reacts, in consequence whereof corrective perceptions are prevented.

(d) The inhibitory effects of ongoing activity are decreased by fatigue. Illustrative of this is our exasperation with the individual who makes minor distracting sounds —such as whistling or tapping—when we are fatigued and attempting to concentrate. We become resentful at this further gratuitous overloading of our capacity to inhibit.

(e) Ongoing activity may be multiple—*e.g.*, we may talk as we drive. Where multiple activity is going on, none of the part activities can be strongly intensified, otherwise one that was would inhibit the others. We can point this up in the statement that intensification and inhibition are reciprocals.

(f) Extremes of inhibitory activity at this level are associated with deviant behavior. Inability to maintain moment-to-moment inhibition results in failure to carry on goal-directed behavior, such as one finds in manic states, while excessive inhibition may be associated with depression (Cameron, 1945).

2. We indicated earlier that the second force comes into play when the exclusion of disturbing action tendencies cannot be achieved by the unaided inhibitory action of the ongoing activity. Under these circumstances, linkage takes place with behavioral patterns that are distinguished by the fact that they develop exceptional degrees of intensification. These are motivations such as prestige, self-respect (will power), competition.

It will be noted that there is a relationship between the forces operating at this second point and those operating at the third point, to be discussed below. Their relationship

consists in the fact that while the first force is inherent in the constitution, the second and third are largely determined—at least with respect to their selectivity—by individual experience and cultural indoctrination. The second and third differ in that while we are aware of the action tendencies that operate at the second level to exert inhibition of the intrusive behavior, we are not aware of those that operate at the third level. One of the major advances in psychotherapy has consisted in a shift of interest from the second to the third force, from "will power" to the so-called "unconscious." Interest, however, is being revived in inhibition at this second level in terms of the psychiatrist's work on remotivation, rehabilitation, and retraining.

3. Earlier we stated the third force in the following terms: Long-established action tendencies, especially if intensified, continually inhibit all action tendencies that might interfere with them. What is excluded is what is disturbing, not only to a passing activity—such as reading—but to the functioning of enduring parts of our personality.

We may recognize that these basic action tendencies—though we may not be explicitly aware of them at a given moment—are in a sense in continual expression insofar that they determine the "kind" of person we are and thus contribute, in greater or lesser measure, to our every response. Hence exclusion is continuous, and the mere approach of the disturbing action tendencies to expression often is accompanied by uneasiness and actual anxiety. The strength of the excluding force is derived from the intensity of the need to continue the long-established basic activity—*e.g.*, the passivity or the sex avoidance patterns.

These long-established action tendencies most commonly fall into two main categories. The first consists of those action tendencies that are derived from particularly disturbing earlier experiences—deprivations, frustrations, periods of severe anxiety. The second category consists of those laid down as part of our cultural indoctrination and therefore endowed with those imperatives that a given culture employs to ensure its stability. These imperatives are driven home by the use of the feeling of guilt and shame, the use of rewards and punishments—both in the everyday sense and in the form of ecclesiastical and magical dicta.

A statement of considerable importance requires to be made at this point: Basic concepts (and all other designs for action) of cultural origin possess inhibitory powers in virtue of and to the extent of their degree of intensification. Such inhibitory powers are not an attribute of the content of the concept. Thus the inhibitory powers of the concept that an individual may hold to the effect that hatred of one's mother is bad are not inherent in the content of that belief, but are dependent upon the intensity of that belief. This is a matter of considerable significance, since it means that whatever beliefs are strongly indoctrinated by a given culture will exert these automatic and profoundly inhibitory powers on all deviant action tendencies. Similarly, it serves to explain the fact that beliefs and designs of behavior that we in our society consider innately disruptive can exist in other cultural groups without producing any personality damage.

In our society, these basic concepts have to do primarily with sexuality and aggressiveness, but, as has been indicated, they need neither be limited to these nor include them. We may go further and say that in this characteristic of personality functioning—namely, the possibility of imparting intensification, and therefore inhibitory powers, to any set of beliefs—lies the explanation of much of cultural lag (a matter of grave danger in this period of maximal need for adaptation), much of the germinal bed of deviant behavior, because of the conflict between indoctrinated beliefs concerning personality function and the actual realities. And that, contrariwise, manipulation of this characteristic in terms of our growing knowledge of human behavior and the rapidly changing needs of our society will permit of great forward progress in regard to both individual and social functioning.

Because of the forcefulness with which each society attempts to indoctrinate its members, these basic beliefs are particularly difficult to manage and modify. Once established, manipulation is possible at present primarily through depth psychotherapy and

through the assistance of disinhibiting agents such as pentothal and sodium amytal.

4. In regard to the fourth force—which consists in the trend toward expression in reality, fantasy, or symbolic form exhibited by all intensified action tendencies—we may state it as axiomatic that all intensified behavior tends toward expression, and through expression ultimately gains discharge of its intensification. This is true of a great series of action tendencies, which ranges from the temporarily repressed urge to continue a task that has been interrupted (Rickers-Ovsiankina, 1928), such as adding a column of figures, through the tendency to talk, fantasy, and dream about a harrowing experience such as being trapped in a burning building, and includes the tendency for repressed trends, such as a latent homosexuality, to appear in symbolized form in dreams.

The tendency for harrowing experiences to express themselves can be seen as the need for discharge and desensitization. Some experiences—such as those of a boy whose foot had been caught in a railroad switch, from which he had been able to pull free only when the train was yards away—are so severe that they require expression not only in talking out but also in fantasy and in dreams. Once some degree of desensitization has been achieved, they are often inhibited from everyday discussion but may appear at intervals long afterwards in dreams. They clearly have nothing to do with wish fulfillments.

The expression of repressed urges in dreams is well documented, and at one time gave rise to the erroneous assumption that all dreams were wish fulfillments (Freud, 1935). It is true that in every culture a number of intensified action tendencies are forbidden expression in reality by that society, and hence the organism seeks to gain their gratification and consequent desensitization through expression in dreams.

The primary value, then, of the talking out, fantasying, and dreaming of intensified action tendencies is not that of wish fulfillment, but is that through such means the organism desensitizes and assimilates intensified—and hence potentially disturbing—action tendencies, and thus continually attempts to return to its most effective level of functioning.

This continuous urge of intensified action tendencies toward expression is part of the wider process of the normalization of functioning. The individual not infrequently finds himself in a dilemma in consequence of this—should he act on a short-term basis and immediately attain the maximum degree of normalization through inhibiting disturbing action tendencies; or should he act on a long-term basis and, by allowing the disturbing action tendencies to gain expression and thus desensitization and assimilation, ultimately gain a greater degree of normalization.

In recapitulation, we may say that there is a constant interplay between the forces of normalization and those inhibitory forces derived from basic concepts. Putting this in other words, one can see here the conflict between the urge of the individual to normalize himself, and the necessity imposed by the basic concepts that he has accepted from society that require that certain action tendencies are not expressed at all, or are expressed only in ways acceptable to his society.

SUMMARY

1. The minute-to-minute effectiveness of the individual is maintained in part by mechanisms that inhibit potentially disruptive behavior.

2. The term inhibition has been used as being much broader than suppression and repression, and as showing interrelationships not recognized when these latter terms are used—*e.g.*, with such diverse matters as concentration and dissociation, the resumption of interrupted tasks, depressive reactions and manic states.

3. The inhibition of potentially disruptive behavior is described in terms of an interplay between four main forces:—

(a) The transitory inhibition exerted by the ongoing activity of the moment.

(b) The intensification of inhibition through integration with stronger motivations.

(c) The persistent inhibition exerted by basic concepts laid down by intense personal experience or by cultural indoctrination.

(d) The inherent tendency of the individual to normalize his behavior; in this instance, to desensitize and integrate inhib-

ited, intensified action tendencies by obtaining expression for them in reality, in fantasy, and in dreaming. This constitutes a denial of the assertion that the principle of wish fulfillment is of universal validity in explaining dream formation. Normalization is posited as a factor of major importance in psychodynamics.

4. Stress has been laid on the fact that basic concepts exert their inhibitory powers in virtue of their degree of intensification, and not in virtue of their content. This has immense significance in understanding some of the origins of deviant behavior in terms of the divergence between intensely held cultural beliefs and the actualities of human activity. It has no less significance in illuminating the fact that beliefs and designs for behavior held to be noxious in one society may in another show no evidence of producing personality damage.

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THE CONFERENCE ON PSYCHIATRIC EDUCATION

A PROGRESS REPORT

The Conference on Psychiatric Education, under the auspices of The American Psychiatric Association with the Association of American Medical Colleges, will open on June 21, 1951, at Cornell University, Ithaca, New York. It will last not less than 7 or more than 10 days.

The general direction and program planning for the Conference are the responsibility of a Planning Committee of 27 members.[1] At its first meeting at Lake Placid, New York, October 21-22, 1950, the Committee determined that the Conference should devote itself to psychiatry in undergraduate medical education, leaving the problems of postgraduate or specialistic training to a later Conference.

Further, the Planning Committee decided that the Conference should orient its study of medical education by a basic consideration of community needs, what they are, how medical education is meeting them, how psychiatry contributes to this end, and what further steps may be taken to meet the needs. The Planning Committee proceeded to outline five major study areas upon which the Conference agenda could be built:

1. *Community Needs—Rural and Urban.*—What does the community need and expect of the doctor in dealing with persons as well as diseases, with groups as well as individuals, and in the management of human relations? Changes in society and social structure create new needs in the community, both rural and urban. In turn these needs call for changes in the teaching of medicine. In addition to what we can answer ourselves or learn from general practitioners and morbidity statistics, we can explore the opinions of a wide variety of persons, for example, clergymen, school teachers, social workers, lawyers, penologists, personnel managers, and parents. Also public health officers and medical or welfare agencies can supply facts and indices of community health.

Recognizing that there are large gaps in our psychiatric knowledge and understanding, which limit our capacity to meet the community needs and expectations, the formulation of these needs may, nevertheless, serve as a challenge and a useful frame of reference for the teaching of psychiatry in medical schools.

2. *The Student—His Adaptation and Progression.*—The medical student brings to the study of medicine a body of knowledge, folklore, sentiments, and values concerning man's behavior that has been derived from his family and peers, from the church and from school, as well as from formal instruction in the social and biological sciences. Such attitudes and information variously predispose the prospective physicians in their developing relations with patients and in the evaluation of further knowledge of the dynamics of behavior. A major contribution of psychiatric education is a better understanding of the student's attitudes, the growth of personal maturity, and the management of his own feelings and attitudes.

The commission should review such topics as these: the assets, liabilities, and motivations the student brings with him; the influence of the students' economic circumstances; the changing pressure of our society; the effect of the learning situation, especially instruction by example in the clinical areas; the maturing effect of responsibility for patient care; the effect of teachers' attitudes; and the consequences of such administrative influences as the premedical requirements and medical college admission policy upon the type of student ultimately admitted to the study of medicine.

3. *The Setting—The Medical School as it Exists Today: Biases, Deficiencies, Potentialities.*—A summary of the medical school milieu that arose to meet demands of the past in accord with past medical concepts; and how changing needs, knowledge,

[1] The members of the Planning Committee are as follows (the asterisk indicates Executive Committee members): Drs. Raymond B. Allen, University of Washington; Donald Anderson, A. M. A., Chicago; Arthur C. Bachmeyer, Univ. of Chicago; Leo Bartemeier, Wayne University; George P. Berry, Harvard University; Karl Bowman, University of California; Ward Darley, Univ. of Colorado; F. G. Ebaugh, Univ. of Colorado; F. J. Gerty, Univ. of Illinois; Alan Gregg, Director, Medical Sciences, Rockefeller Foundation; Carlyle Jacobsen, State University of New York; Maurice Levine, Univ. of Cincinnati; Theodore Lidz,* Johns Hopkins University; Vernon W. Lippard,* Univ. of Virginia; H. E. Meleney, New York University; H. H. Merritt, Columbia University; John McK. Mitchell,* Univ. of Pennsylvania; H. C. Poncher, Univ. of Illinois; Clifton Perkins, Maryland Commissioner of Mental Hygiene; George N. Raines, Office of the Surgeon General, U. S. Navy; John Romano, Univ. of Rochester; Benjamin Spock, Rochester Child Health Institute; Harvey Tompkins, Veterans Administration, Washington, D. C.; Seymour Vestermark, U. S. P. H. S., Division of Mental Hygiene; John C. Whitehorn,* Johns Hopkins Hospital; S. Bernard Wortis,* New York University; John B. Youmans, Vanderbilt University. Dr. Daniel Blain is the Executive Director of the Conference.

and pedagogical skills, with particular reference to changes in psychiatry, now require alterations in the medical school environment. This area includes changes in medicine generally, changes in psychiatric perspective, impact of social sciences and conceptions of human development; also examples of good and poor settings and recent experiments to alter them.

4. *General Principles, Content, and Methods of Teaching Psychiatry in the Undergraduate Medical Period.*—Inquiry into the nature of the body of knowledge (growth and development of human beings in our society; concepts of health and disease; physician-patient relationships; patterns of adjustment and maladjustment) that may be incorporated as content, in addition to the necessary knowledge about psychiatric illnesses.

Further inquiry into which types of learning experiences the undergraduate medical student may participate in with teacher and patient, and at what stages these should take place in order that the student may obtain a more comprehensive undertaking of his functions as a physician in our society.

5. *Administrative and Integrative Patterns of Organization.*—Inquiry into current and planned medical school curricular patterns; ways in which psychiatry can be integrated intimately with other departments in school, hospital, university, and community; structure of psychiatric departments (whole and part-time status, budget, proximity to other clinical departments, nature and use of teaching and clinical facilities).

Preparatory Commissions are assigned to each of the five study areas.[2] The Preparatory Commissions are responsible for breaking the study area outlines into the specific topics and subtopics that will constitute the detailed agenda of the Conference itself; and for bringing to each of these topics and subtopics such up-to-date information, data, and opinion as are basic to a consideration of them. Each Commission is encouraged and assisted to seek the advice of authorities in its study area. By bringing to the Conference a well-selected, digested, and organized body of material for consideration, the Preparatory Commissions will enable the delegates to avoid dilatory extensions of time and effort into questionable, irrelevant, or minor detail.

Tentative plans for the operation of the Conference itself are taking shape.

[2] The Chairmen of the Preparatory Commissions are: Dr. Kenneth Appel, Univ. of Pennsylvania (Community Needs); Dr. Carlyle Jacobsen, State Univ. of New York (The Student); Dr. John Romano, Univ. of Rochester (The Setting); Dr. Maurice Levine, University of Cincinnati (General Principles); Dr. Ward Darley, University of Colorado (Administrative and Integrative Organization).

It is planned that approximately 70 delegates will be broken into 6 working groups of about 12 each for every working day of the Conference. All working groups will consider the same topic at the same time. The composition of the groups and the chairman will be changed from day to day, so that over the course of 7-10 days broadly representative points of view will be brought to bear on the topics. To tie in the work of the Preparatory Commissions with Conference deliberations, a representative of a Commission will sit in as "consultant" with each working group when a topic in that Commission's field is under consideration.

At the end of each Conference day, the chairman of the working groups will meet to prepare summary reports and recommendations of the day's proceedings. An adequate secretarial staff will be on hand to reproduce these for presentation to a plenary session of the Conference the following day or as shortly thereafter as possible.

The plan calls for an actual working conference of a representative number of persons, with active participation by all. To be effective, this plan requires a severe limitation on the number of participants. It is expected that a considerable measure of agreement may be found, but not complete agreement, and that the extent and practical significance of agreement and divergence will be pointed up in a fashion that will give to all of us concerned a better perspective and a more confident sense of direction, for the improvement of medical education.

Such expectations will be fulfilled, however, only if "all of us concerned" assume an individual responsibility for the success of the Conference. Whatever your specialty may be—public health, private practice, industrial psychiatry, hospital administration, government service, mental hygiene clinic, and the like—it is important that we learn what you need and expect from the undergraduate medical school.

Please send your comments, questions, and suggestions to the Executive Office of the Conference at 1624 Eye Street, N.W., Washington 6, D.C., where they may be passed on to the appropriate commissions for consideration.

JOHN C. WHITEHORN, M.D., *Chairman,*
Conference on Psychiatric Education.

HISTORICAL NOTES

A FIRST BICENTENNIAL—THE PENNSYLVANIA HOSPITAL—1751 to 1951

In 1951 the Pennsylvania Hospital is looking backward over 200 years to its beginnings. Some unusual psychiatric events bear repeating.

When in 1751 a petition for a hospital was presented to the Assembly of the Province of Pennsylvania it stated first that no provision had been made for the care of persons "distemper'd in mind and depriv'd of their rational faculties" and then went on to speak of the "relief of sick and inhabitants."

Benjamin Franklin, coming to the help of Dr. Thomas Bond, pushed the charter through, became the first Secretary of the Board of Managers, and wrote and printed the first history of the hospital in 1754.

On February 10, 1752, three patients were admitted to a house rented as a temporary hospital; one of them was a mental patient. Three services were instituted, which have developed into medical, surgical, and psychiatric. Here was the first treatment in the United States of the insane as sick people.

The first provision of hospital facilities was so welcome that an inrush of mental patients filled the space available in a building erected in 1756 and still used, and an addition put up in 1796.

It was here that Benjamin Rush, now the "patron saint of psychiatry," offered in 1797 to devote himself to all "insane" patients not the particular patients of other physicians. In 1798 he proposed and carried out occupational therapy. In 1810 he followed with a charter for the care of mental patients that was adopted by the Managers. This charter included proper classification, exercise, amusement, employment, sanitation. Paragraph 4 read as follows: ". . . . that an intelligent man and woman be employed—to direct and share in [the patients'] amusements and to divert their minds by conversation, reading. . . . . While we admit madness to be seated in the mind, by a strange obliquity of conduct we attempt to cure it only by corporal remedies."

In the 1830's the increase of the numbers of all sorts of patients overcrowded the 8th Street hospital and plans were made to move the mental patients to the country. In 1841 new buildings were ready at 44th Street and there the young Dr. Thomas Kirkbride carried out all of Rush's good ideas while he discarded outdated ones and added constructive methods of his own. It was at Dr. Kirkbride's house [1] that the 13 Founders of the (now) American Psychiatric Association met at dinner on October 15, 1844, before they formally created the Association at the Jones Hotel [1] next day.

In 1930 the Hospital, looking toward preventive medicine, added an Institute for the treatment of neuroses and speech difficulties. Inevitably a children's unit and a nursery school and a department for research have come into being.

In 1751 the insane in the Pennsylvania Hospital were first treated as sick people. In 1851 mental patients were treated in a hospital designed for them with such interest and enthusiasm that many were cured. In 1951 interest in psychoses continues, but extends to the neuroses and emotional problems of everyday people and their children.

EARL BOND, M. D.

[1] For illustrations see page 44 of *One Hundred Years of American Psychiatry* (Columbia University Press, 1944).

CORRESPONDENCE

MENTAL HEALTH PROGRAMS OF THE STATES

Editor, AMERICAN JOURNAL OF PSYCHIATRY:

SIR: In a communication published under the above caption in the December 1950 number of the JOURNAL, Dr. Paul V. Lemkau disagrees with the Council of State Governments which, in a recent report, considered it unwise to designate some other state department than that which administers the state hospitals as the authority to act for the state under the terms of the National Mental Health Act governing Federal grants-in-aid for mental health purposes. He considers it doubtful that a psychiatric or mental health service controlled exclusively by a department of government concerned with hospitalization can achieve the local organization and integration with the general health program that can be accomplished when the integration is in the hands of the health officer. The purport of his communication seems to be that the state health department should invariably be the authority designated to administer, in the state, the Federal grants-in-aid. He admits, however, that in all but a few areas of the country the hospitals form the major source of the personnel required.

This issue was given much consideration when the Mental Health Act was pending in Congress. The first Bill introduced provided that the state health department would be designated as the authority. When, however, it was explained that the states had always made separate provision for the mentally ill, and that many had well-established departments for the purpose, the Bill was revised and, as passed, it provides that the state mental health department will be designated, but in states in which a separate department had not been established it would be considered that the state health department was also the state mental health department. Experience is therefore being obtained with both forms of administration.

Dr. Lemkau considers that the "essential and basic problem" in public mental health administration is that of actually reaching the people who need help and education, and that "the skills here involved are *not* those of the psychiatrist and his aids; they *are* the skills that are the basic stock in trade of public health personnel." Equally basic, however, and even more essential are the skills required in discerning, understanding, and proceeding effectively when mental health conditions and problems among those who need help and education require skilled attention. It is important also that the information and advice given in education of the public be appropriate and reliable. Considering the amount and character of instruction and experience considered necessary for adequately qualifying for psychiatric and mental health practice, it seems doubtful that, with perhaps some exceptions, the present public health personnel are by education and experience qualified for this special service. It should be remembered that, only a few years ago, psychiatry and mental hygiene were not provided for in general medical and nursing education and practice. Even yet the provision made is in many, perhaps most, places far from adequate. Also, the recent quickening of interest and zeal for participation in mental health service has spread so widely that the demand for better service and facilities far exceeds the means of supplying it. Consequently, there is a tendency, even among those who deplore it, to resort to short, inadequate expedients in education and service. This may, to a limited extent, because of the urgency be inevitable for a temporary period. If widely and continuously resorted to, however, standards accepted in mental education and service will deteriorate. In a recent medical publication relating to the establishment of psychiatric service in general hospitals, it is advised that "general duty nurses can be trained 'on the job' for psychiatric nursing."

Dr. Lemkau considers that as "the health officer makes use of specialists in pediatrics, orthopedics, venereology, cardiology, tuber-

culosis, etc., it would seem logical for him to use psychiatric personnel as he uses these other medical specialists, and logical to assume that he could use them with equal [?] skill, once an initial experimental and learning period were passed." This seems to assume that the health officer, in his medical education and practice, had received instruction and experience in psychiatry equal to that which all physicians obtain in the fundamentals of the other specialties mentioned. Also, the "initial experimental and learning period" incidentally mentioned seems to indicate that less education and experience are considered necessary to qualify for mental health service than for other forms. An "experimental" period for beginners seems rather risky.

In considering the state department to be designated the authority to administer, in the state, the Federal grants-in-aid for mental health purposes, it must be accepted that the standards and provision for general or for mental health service are far from uniformly adequate in every part of this great country. In a communication recently issued by the U. S. Public Health Service it is stated that 40 million Americans have no local public health service whatever, and millions of others have only inadequate services by part-time personnel. The state department that administers the state mental hospitals has, in every state, at least a nucleus of psychiatrically experienced personnel. It seems reasonable to expect that, in instituting additional mental health developments, their coordination or integration with the existing provision would be given first consideration. It is, however, stipulated that funds from the Federal grants-in-aid must not be used for the maintenance and ordinary treatment of hospitalized patients. The National Mental Health Act is designed for the promotion of psychiatric and mental health research and education, and of outpatient and other provision for the early treatment and prevention of mental illnesses and disabilities, in direct relations with the communities. There seems to be no obstacle in the terms of the Act to using funds from the grants-in-aid for the support and promotion of these activities where they are engaged in by the mental hospitals and the department by which the hospitals are administered. The state hospitals, with their many thousand patients, are a rich field for research and education and, notwithstanding meagre support and other adverse conditions, members of the hospital personnel and the departments are making a substantial contribution to the development of these important activities. Educational work and development are also receiving much attention in the hospitals. Federal aid in developing them would be a fruitful contribution to the advancement of psychiatric knowledge, and of treatment and prevention of mental illness and disability.

Of great significance and importance are the indications that the hospitals are emerging from the isolation, penury, and neglect that have heretofore impaired their usefulness and retarded their advancement. The Council of State Governments begins their report with the statement: "Never before has there been so much public interest in mental health and in the facilities provided for the care and treatment of the increasing numbers who are being admitted to our mental hospitals . . . . in every state there is a growing demand for more effective health and hospital programs." This is one of many indications that the advancement of the hospitals as curative and preventive instrumentalities may be confidently anticipated. Of particular interest in the promotion of early treatment and preventive service, which is one of the avowed objects for which the Federal grants-in-aid are designed, is the extension of the activities of the hospitals into the communities that they serve. This is in accordance with a policy persistently advocated by the late Dr. Adolf Meyer, who was instrumental in the establishment of the first psychiatric outpatient service in New York, and the first appointment of a specially qualified psychiatric social worker. In every state provision is now made for follow-up and rehabilitation service for patients who, after a period of hospital treatment, have returned to the communities. Outpatient and social service are engaged in by the hospitals, in many instances in cooperation with local public and privately supported mental health organizations and activities in the communities. The physicians, nurses, and social

workers of the hospitals are, by their studies, and their relations with patients, relatives and friends, health and welfare organizations, private practitioners, and local and state officials concerned with mental health conditions and problems, remarkably well informed of the personal, family, educational, occupational, and social factors that contribute to the prevalence of mental health problems and disorders in the communities. They are especially qualified to participate and lead in the community services that the Federal grants-in-aid are designed to promote.

With the advancement of psychiatry and mental hygiene in medical and nursing education and practice, and the diffusion of mental health knowledge in the general population, better understanding and capability eventually prevail among all who are particularly concerned with the advancement of health, welfare, and behavior. To make an issue, however, of integrating mental health in a general health program seems, at the present stage of psychiatric and mental hygiene education and practice, and of the inadequate extent and standards of provision for general as well as mental health public service, to be premature and not realistic. More readily obtainable and significant for the development of a sound, dependable, comprehensive mental health program would seem to be the promotion of the provision already established and its coordination and perhaps eventually its integration with the new developments.

It seems reasonable for the members of the Council of State Governments to assume that the state department that is most interested and informed concerning the mental health conditions and problems in the state, and that administers the provisions made by the state for dealing with them, is better qualified to administer the Federal grants-in-aid than some other department that has heretofore shown no particular interest in mental health nor undertaken any mental health service. It is required that every two dollars of the Federal grants must be matched with at least one state or local dollar, and it is officially reported that last year about two state dollars were matched with every dollar of the grants. It would seem, therefore, that the views of the Council of State Governments and of the state authorities would be given much consideration in determining the administration and use of the Federal grants-in-aid.

WILLIAM L. RUSSELL, M. D.,
New York, N. Y.

COMMENT

HOSPITALIZATION OF THE MENTALLY ILL

Because of a broad and rising public concern with standards of care for mental patients, for several years Federal Security Agency officials have been receiving requests for suggestions and advice regarding proposed changes in mental hospital laws. In May 1949, attorneys of the Federal Security Agency and psychiatrists at the National Institute of Mental Health, Public Health Service, which is part of the Agency, discussed this problem with the National Advisory Mental Health Council. This advisory council to the Federal mental health program recommended that a draft act be framed to reflect widely accepted modern concepts of sound medical and legal practice.

A drafting committee was organized and got to work shortly after this meeting. It included Mr. Franklin N. Flaschner, Boston attorney who had made an intensive study of hospitalization laws; Miss Gladys Harrison and Mr. Israel L. Sonenshein of the Federal Security Agency General Counsel's Office; Dr. Winfred Overholser, Superintendent of Saint Elizabeths Hospital, and, from the National Institute of Mental Health, Drs. James V. Lowry, Riley H. Guthrie, Dale C. Cameron, and the writer. After review by some 40 lawyers and psychiatrists outside the Agency to whom a preliminary draft was sent last winter, a draft act was released on advice of the National Advisory Mental Health Council in September 1950; copies were distributed to State Governors and mental health authorities. It was entitled "A Draft Act Governing Hospitalization of the Mentally Ill." We may also note that the general principles set forth in the draft had been accepted by the Council of State Governments in its report, *The Mental Health Programs of the 48 States*, to the Governors' Conference of June 1950.

The history of the draft act since its release has been most gratifying. Announcement in the newspapers and professional journals brought a flood of inquiries, not only from psychiatrists but also from state legislators, attorneys, mental hygiene societies, and civic groups. Thoughtful comments and valuable criticisms have been received; as many of these as possible are reflected in the recently printed version of the draft act, which is now available from the National Institute of Mental Health. Quite evidently, not only the professions directly concerned but also the public generally are taking an unprecedented interest in mental hospital problems and particularly in legislation dealing with hospitalization of the mentally ill. In many states, legislative committees are drafting specific proposals; in other states, such proposals are already the subjects of study and action.

The draft act was offered by the Federal Security Agency as an aid to these state legislatures. Not every one of its provisions will be acceptable to all interested persons and groups. Furthermore, adaptations will be required to fit it into existing state statutory and administrative frameworks. In fact, in the opinion of the drafting committee, the comments and annotations prepared along with the draft act may be more important than the draft act itself. If these stimulate further discussion and study of existing statutes and of the basic medicolegal considerations involved in hospitalization of the mentally ill, the purpose of the committee will have been attained.

The draft act seeks to provide three basic assurances: (1) maximum opportunity for prompt medical care, (2) protection against emotionally harmful experiences, and (3) protection against unwarranted confinement. These objectives are sought through such measures as facilitation of voluntary hospitalization, which is used for barely 10% of admissions at the present time in the United States, in contrast to almost two-thirds of admissions in Great Britain. The draft also provides simple procedures for involuntary admissions upon medical certification, with opportunity for prompt resort to judicial proceedings. To avoid emotionally harmful or degrading experiences for patient

and family, the court procedures are required to be as informal as possible and attendance of the proposed patient may not be compelled by the court. In short, the act emphasizes the fact that hospitalization is a medical matter, to be obtained promptly and easily when needed, and that the role of the courts is to insure against unwarranted deprivation of personal liberty.

For the psychiatrists who worked on the drafting committee, it was a most rewarding experience to collaborate with lawyers and learn to understand their views on the points of apparent conflict that arose between legally protected rights and medical need. Actually, in every instance, the solutions reached did not represent compromise but rather an actual reconciliation of legal and medical requirements. The attorneys were especially sympathetic with the psychiatrists' desire to remove from the statute books such degrading and medically meaningless concepts as "insanity" and "commitment," substituting the more inclusive and less invidious phrase "hospitalization of the mentally ill." They also were interested in making a clear separation of the legal procedures related to hospitalization from those related to adjudication of incompetence.

Lawyers, as well as psychiatrists, realize only too well that legislation alone cannot solve our intricate mental hospitalization problems. However, legislation is one of the important points of attack on these problems. As our laws are improved, discrepancies between statutes and practice will be thrown into higher relief; demands for implementation of these improved statutes will undoubtedly receive broader support. While we devote efforts to obtaining more functional buildings, improved equipment, additional skilled personnel, more intensive research, and better hospital administration, we must also remember that no state can yet claim to meet fully the hospitalization law standards set forth as a goal by Isaac Ray in 1869.

R. H. Felix, M. D.

Le Bon on Socialistic Ideologies

In his book, *"The World Unbalanced,"* published in 1924, Gustave Le Bon made these statements:

"Among economic errors which disturb the world at present we have the illusions of socialism. Presented under various forms, all agree on one formula: the socialisation of wealth."

"Communities find themselves today threatened with vast upheavals by the new formula: the socialisation of wealth. If we believe its apostles, it should create perfect equality and produce universal felicity. The magic promise has rapidly spread over the working classes of all countries."

"Are the interests of the capitalist really opposed to the common interest? Can it truly be said that, in present-day communities, 'work is not done to the profit of everybody, but solely in the interest of a few'?

"On the contrary, it is in reality the vast majority of workers who benefit by the ability of the *elite*. It has always been so since the beginning of the modern industrial evolution. It was never the common worker who made the progress by which he profited."

"The final result of these conflicts is not yet to be foreseen. We are sure that the nations will always be guided by their *elite*. But the momentary triumph of inferior elements might, as in Russia and Hungary, cause irreparable ruin."

"To the bosses of the working classes 'the great twilight' seems very near. In reality it is a great night which the realisation of their dreams would spread over the world."

"The main results of socialistic influence on Parliament in various countries have subjected many industries to a collective governmental management, *i.e.*, a general interference by the State. Experience has demonstrated its ruinous effect in a hundred cases.

"If these consequences are identical in all countries and all industries, it is simply due to the fact that collective management destroys the most powerful psychological springs of human action: personal interest, sense of responsibility, initiative, will-power, in a word, the elements which have generated all progress which has transformed civilisation."

NEWS AND NOTES

GERIATRICS.—An intensive research program has been inaugurated in New York State to discover what conditions are associated with mental disease among the aged. The project will be carried out by the New York State Mental Health Commission in cooperation with the Council on Aging of the Council of Social Agencies in Syracuse. In order to determine to what extent the provision of social and related community services may prevent mental breakdowns among the elderly the Syracuse research unit of the Commission will conduct a pilot experiment in such services. The resulting information will then be used to formulate a master mental health plan for communities throughout the state.

The following panel of authorities will act as consultants to the project: Dr. F. C. Redlich, professor of psychiatry, Yale University; Professor A. B. Hollingshead, department of sociology, Yale University; Dr. John Claussen, social scientist, National Institute of Mental Health; Dr. Alexander Leighton, professor of industrial sociology, Cornell University; and Dr. F. C. Richardson, Harvard University.

PUBLIC KNOWLEDGE OF PSYCHIATRIC SERVICES.—A public opinion poll recently made in Phœnix, Arizona, under a National Institute of Mental Health grant to the Survey Research Center of the University of Michigan, revealed the following facts through interviews with 500 randomly selected adults:

Only a third of them would be willing to visit a psychiatrist. A considerably larger proportion did recognize that a psychiatrist would be the proper person to consult for what they termed "mental problems" or "nervous disorders." But for advice on marital, child behavior, and other problems they would be likely to consult clergymen rather than psychiatrists or even family doctors. Less than half the people interviewed were aware of the services available in Phœnix to help children with emotional or behavior difficulties, and less than one-third knew of the services or agencies offering help with marriage problems.

The complete report of this survey, which was undertaken as part of the program of the Phœnix Mental Health Center, will be issued shortly by the Survey Research Center of the University of Michigan.

AMERICAN PSYCHOSOMATIC SOCIETY.—The eighth annual meeting will take place at Chalfonte-Haddon Hall, Atlantic City, N. J., Saturday, April 28, 1951. The program for this meeting will be available upon request after March 15. There will be a registration fee for nonmembers of $2.00; for students, etc., $1.00. For further information write to Dr. Sydney G. Margolin, secretary-treasurer of the organization, at 714 Madison Ave., New York 21, N. Y.

FORTY-NINTH CONGRESS OF THE PSYCHIATRISTS AND NEUROLOGISTS OF FRANCE AND OF FRENCH-SPEAKING COUNTRIES.—This Congress will take place at Rennes, July 16-22, 1951, under the direction of the president, Dr. Giraud, physician to St. Anne Psychiatric Hospital, Paris.

Those wishing to contribute papers should address the general secretary, Dr. Paul Cossa, 29 Boulevard Victor-Hugo, Nice. The local secretary is Dr. Sizaret, 221 Avenue General Leclerc, Rennes.

JOURNAL OF NEUROPATHOLOGY AND CLINICAL NEUROLOGY.—The first number of this new quarterly appeared in January 1951, under the editorial direction of Dr. George B. Hassin, as chief editor, and Dr. Percival Bailey. We welcome this new periodical which, as its name implies, will be devoted chiefly to neuropathology and clinical neurology but will carry occasional articles in allied fields such as neurophysiology and neurosurgery. Correspondence regarding the journal should be addressed to Dr. Hassin at the Illinois Neuropsychiatric Institute, 912 So. Wood St., Chicago 12, Ill.

WORKSHOPS IN RORSCHACH METHOD.—Western Reserve University will conduct three workshops, introductory, intermediate, and advanced, in the Rorschach method, during the month of June, 1951. Each workshop lasts five days and registration is limited to 25 persons. Dr. Marguerite R. Hertz, associate clinical professor of psychology, will be the instructor. The fee is $40 per workshop.

Inquiries may be addressed to Dr. Marguerite R. Hertz, Department of Psychology, Western Reserve University, Cleveland 6, Ohio.

ASSOCIATION FOR RESEARCH IN NERVOUS AND MENTAL DISEASE.—The 31st annual meeting will be held December 14 and 15, 1951, in the Roosevelt Hotel, New York City. The topic will be "The Treatment of Mental Illness" and will include consideration of all current therapies.

DR. SACKLER TAKES PART IN RADIO SERIES.—On invitation of the Columbia Broadcasting System Dr. Arthur M. Sackler of the Institute on Psychobiological Studies of the Creedmoor State Hospital of Queens Village, N. Y., participated in the Public Service Forum entitled "You and the World," on January 19, 1951.

Dr. Sackler's subject was the Institute's work on the development of histamine drug therapy in mental illness, which the Columbia Broadcasting System has noted as one of the major science stories of 1950 after an award was given this work by the New York State Medical Society.

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION.—The 1951 convention of this Association will take place September 8 to 15 at New Castle, New Hampshire. The Northern New England Occupational Therapy Association will be host to the convention. The program, arranged by Eileen Dixey of New Hampshire State Hospital, Concord, will concern the application of new medical developments to occupational therapy. Co-chairmen of the convention are Eleanora Chernewski of the VA Hospital, Togus, Maine, and Margaret L. Blodgett of the U. S. Marine Hospital, Brighton, Mass.

DR. HENRY A. REYE DIES.—Dr. Reye, who died on December 6, 1950, had been a member of The American Psychiatric Association since 1924 and had practiced psychiatry in Detroit since 1916, except for a period of army service during World War I. He was born in Eisenach, Germany, in 1886, immigrated to the United States during his teens, and graduated from the University of Michigan in 1913. He was a diplomate of the American Board of Psychiatry and Neurology. From 1918 to 1946 Dr. Reye was professor of neuropsychiatry at Wayne University College of Medicine. He was especially interested in the fields of philosophy and ethics. A memorial sketch in the Detroit Medical News speaks of him as "the dean of psychiatry in this midwestern area."

VA HOSPITAL, DOWNEY, ILL.—The 1951 seminars in "Modern Concepts of Psychiatry," the first of which was held on January 10, will continue on March 21, April 2 and 17, May 2, and June 6 and 20, and are conducted by outstanding practitioners in psychiatry.

These seminars have been arranged by Dr. Jules H. Masserman of Northwestern University in conjunction with Dr. Byron S. Cane and Dr. A. Rodriguez of the Downey Hospital, and Dr. B. A. Cockrell of the VA Regional Office, Chicago. There is no charge for admission.

THE AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY, INC.

The following were certified at New York City, December 18 and 19, 1950.

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BOOK REVIEWS

ALLGEMEINE PSYCHOPATHOLOGIE, Fifth Edition. By *Karl Jaspers.* (Berlin: Springer-Verlag, 1948.)

As a remedy for many of the dubious current popularizations of psychiatry one would like to recommend the book of Jaspers. It has had a history and fate of its own and its approach is radically different from our textbooks on abnormal psychology. The original is written in an abstract, involved style; only a far-advanced student of German will penetrate deep enough into this heavy volume to discover the mines of new insights and brilliant views hidden in its 800 pages.

When the first edition of Karl Jaspers' "Psychopathology" came out in 1913, it became a pioneering landmark for establishing psychopathology as a science of its own, with its strict methodological principles establishing the basic structure of "Verstehende Psychologie," that is, interpretive psychology, a term first introduced by Jaspers. Generations of continental psychiatrists have grown up with this book and every psychiatric clinician, who must have felt the limitations of his daily work when he painfully felt his historical and philosophical insufficiency, was deeply moved when the author in the early twenties left psychiatry to devote his life to profound philosophical studies, most of them never translated. The author's name became connected through these works (which always betrayed his contact with his first efforts) with the philosophical movement toward Existentialism. Contrary to Heidegger's enthusiastic acceptance of Nazism, Jaspers, never a collaborator with evil, became the spokesman of Germany's deepest conscience. He continues a humanistic tradition of old Germany, where the disciplines of philosophy, psychology, logic, and psychiatry were not separated but identified with the same person. But we should remember that years ago the Heidelberg Psychiatric Clinic dedicated its great volume on schizophrenia in Bumke's Handbook to its former colleague, Jaspers, thus documenting the debt they felt our profession owed to him.

The present deep crisis in all Western Civilization, the awareness of our own present national responsibility and the life and death struggle for our survival, might better open up avenues to the understanding of questions of existence of which the individual has become aware only in rare moments of his life—in the ecstacy of love, the anxiety of death, the suffering of destruction, and the solitude of forlornness. The humanistic tradition of psychiatry, suppressed since the middle of the last century through the tremendous development of natural science, has always known about these ultimate experiences that Jaspers tries to make fertile and to revive for our discipline. Communication, anxiety, awareness of our mortality, solitude, decision, being and time, are corner pillars of the system of these philosophers whom we empirical clinicians are so inclined to shrug off as sterile, speculative minds. Our patients, however, know better when they experience their distress. Whether we are aware of it or not, our most decisive activities with our patients are beyond the realm of natural science and technique. They look to us for help for more than their shattered health when the base of their whole life is threatened.

Starting with the delimitation of the science of general psychopathology, its fundamental concepts, prejudices and premises, methods and tasks, the author divides his treatise into six main parts:

First, detailed facts and phenomena of mental life; for instance, the different ways of conscience, experience of space and time, reality and delusion, emotion, instinct and volition, etc. These subjective manifestations are followed by the objective performances of the mental life as perception, orientation, memory, language, thinking, judgment, intelligence, etc. The further chapters deal with somatopsychic and psychosomatic phenomena and the objective facts of expressive psychology. In this section he pays tribute to the possibilities and limitations of handwriting as a psychosomatic symptom which in this country, otherwise so generous with tests, has been for the most part ignored.

The second part deals with interpretive psychology clarifying the basic differentiation of understanding and explaining. The patient's own attitude to his disease is discussed and the whole of understandable connections is identified with "characterology," which we usually call, in this country, psychology of personality, and leave entirely to the "normal" psychologist.

The third main part concentrates on the causal, explanitory psychology, the effects of environment and the body on mental life. The significance of heredity is given, and the various theories in psychopathology are compared (Wernicke, Freud, genetic anthropological approaches).

The fourth part divides the apperception of the totality of the mental life into the synthesis of the different syndromes (diagnostic schemes). The influence of sex, constitution, and race are discussed and the methods, importance, and limitations of biographical material are stressed for the psychopathological basic problem of contrasting the natural development of personality to the process, the sudden break and interruption of normal evolution.

The fifth part gives a sociology and history of psychoses and psychopathies, and the last part entitled: "The Whole of Being Human," is particularly fascinating, because the concepts of psychiatry and philosophy, health and disease, the meaning of practice, psychotherapy, and types of the physicians' attitudes are clarified. His criticism of the methodical base of psychoanalysis, the carelessness with

which etiological connections are rapidly accepted, the exaggerations of both the organic and functional isolated approach are most fruitfully elaborated. Elsewhere in another paper, his thoughts will be presented in more detail, particularly his analysis of the psychotherapist, about whose human role he has no illusions.

It is true that the isolation of the war years and the author's detachment from actual clinical work are to be made partly responsible for painful omissions in a psychopathology that strives to be all-embracing and therefore comes close to being considered outdated and of historical interests only. What would not be surprising in the average German writer becomes a deep regret in the case of such a distinguished author. The vast non-German European literature is ignored. The later developments in psychoanalysis, the projective techniques, the important American contributions, and the whole sociological cultural school are not even mentioned. The modern somatic therapy methods in their psychopathological effects are just touched upon in passing. Perhaps we may hope, in a future edition, that the writer's European spirit may condense some of the discussions on race and heredity (as historically not longer actual) to make space for the progress of the last decade.

In the age of natural science the psychoanalytical revolution of man's picture of himself was inevitable and epoch making. But the revival of the neglected currents of the humanistic tradition in psychopathology in this era of human crisis does not mean an alternative between debunking or flattering human nature, but a recognition of human existence that will ever resist being shackled by any system.

We believe that it is here that Jaspers' challenge is not outdated and may be fruitful in future research. His inquiry seems to us also to show that the disintegration into many psychiatric subspecialities is highly questionable for theoretical and practical reasons. What might be inevitable for research purposes in large institutions and university clinics would be splitting up in practice what belongs together. The reflection on the methods and principles of our work throws new light on the never solved basic problems. It arouses us from rut and routine, these deadly enemies of scientific progress. In a time of rigid standardization and comfortable slogans, it challenges our thinking and comprehension of our scientific and medical responsibility. We have to return to the sources: the experience of astonishment and reverence before the abundance of the psychopathological riddles of human existence.

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PSYCHIATRIC SECTIONS IN GENERAL HOSPITALS. By *Paul Haun, M.D., Med. Sc.D.* ("An Architectural Record Book" by F. W. Dodge Corp. Garden City, N. Y.: Country Life Press, 1950. Price, $4.00.)

The title of this book implies a range of application to include all general hospitals, and it would appear that this is the aim of the author. This deduction is supported by the statement: "It is unfortunately true that many 'General Hospitals,' although professing to give the community every service, have ignored the need for psychiatric facilities in their building programs and in their operational activities" (p. 4). The 80-page contribution characteristically reflects a close applicability to the Veterans Administration hospitals of the United States. That this thought is high in the mind of the author is partly evident in his comment: "It should, of course, be stressed that this weighting of the features discussed is done with respect to a definite group of hospitals serving a specific function and will not be fully applicable to every hospital of like size" (p. 52). In the face of public prejudices and misinterpretations where the mentally ill are concerned and the high plurality of neuropsychiatric patients, Dr. Haun's presentation of hospital plans and pertinent discussions laudably emphasizes needs and forward steps, many of which are very timely and should be carried out. However, it should be noted that for all the hospital plans (9) presented, the "Psychiatric Floor" is invariably placed on the top floor; all plans are for general hospitals of 150 to 240 bed capacity, and, with the exception of plans V and VII, the psychiatric facilities are grouped about a basic 24 beds (4 four-bed wards and 8 single rooms); the exceptions are 18 and 23 beds. Plan IX by architects Butler and Erdman incorporates a psychiatric floor of 24 beds on the sixth floor of a 200-bed general hospital; this plan is a commendable one, especially for Veterans Administration hospitals. When contemplating a psychiatric inpatient service in a community general hospital of more than 75 beds, much thought must be given to the needs and the type and density of the population of that community. Good as Plan IX may be, it cannot serve all communities except as a guiding model. Many communities may choose a ground floor plan to advantage, find the facilities of Plan IX too extensive, too elaborate, and too expensive. Rarely are 4 seclusion rooms, 4 solaria, and 4 roof gardens for psychiatric patients necessary in any general hospital, for many psychiatric services in such hospitals can manage even the disturbed patient without elaborate provision, especially if it be remembered that long-term psychiatric patients have no permanent lease on the general hospital beds any more than have long-term tuberculous patients or geriatric patients. Again, Plan IX is a commendable architectural goal, but in its functioning it still emphasizes far too much segregation and surveillance of the psychiatric patient and sets him apart with prisonerlike feelings and often rebellious reactions for that very reason.

The little volume contains much that is germane to planning for the proper care of a psychiatric patient in a general hospital, but unfortunately it ranks more with the ideal than it does with the practical.

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THE MAGGID OF CARO. By *Hirsch Loeb Gordon, M. D.* (New York: Pardes Publishing House, Inc., 1949.)

"The Diary of Joseph Caro, one of the most illustrious Spanish exiles of the fifteenth century, is a precious document, . . . not only because it sheds new light on the life of an outstanding follower of the eminent Maimonides, ... but primarily because it reports the 'messages' he received regularly from a Maggid, his familiar spirit, giving him advice and foretelling him events to come. . . . 'The Maggid of Caro' is an important contribution to the history of both, the adventures of the mind and of the cultural evolution of the Renaissance."

In these words the medical historian, Arturo Castiglioni, offers an introductory comment to this book, whose author had conducted research in medical history under the guidance of the distinguished Italian scholar.

Joseph Caro, preeminent in his time and ever since as an authority on all aspects of Jewish law, died in 1575 at the age of 87. Seventy-one years after his death came the sensational discovery of a secret diary of the great codifier, wherein he testified that for upwards of 52 years he was visited regularly by an invisible spirit who revealed to him the future and guided his thoughts and actions, including the writing of his famous code, "The Prepared Table" (1565), which reigned a supreme authority among his people.

The finding of this diary was a disturbing event, for it might be thought to cast some doubt on the mental status of the revered jurist who had been regarded as the soundest and sanest of teachers. At all events later commentators passed lightly over or carefully ignored the Maggid phase of Caro's life and work while accepting and promulgating his code.

It was Caro's Maggid, however, that intrigued the author of the present work. He found it to be "a veritable gold mine of psychiatric material." It is the first time this document has been translated in any language and Gordon's book represents extensive and painstaking historical research.

Most interesting are the 60 pages he devotes to the life of Caro. He was born in Toledo 8 years after the terrible Inquisition had been set up in Spain, and when he was 4 years old came the mass expulsion of the Jews. His wandering took him eventually to Palestine, where he died.

In his translations from the secret diary the author gives examples of recorded messages of the Maggid speaking with the voice of Caro, thus suggesting the mediumistic messages of a later day with the qualification that the former are intelligent, clothed in dignified language, and quite in keeping with the religious thought and belief of the time and the people.

Such a history as this of a case of a special form of lifelong "possession" opens the never-resolved question of normal-abnormal-pathologic mental experience. Whether a hallucination is agreeable with health or symptomatic of illness seems to depend upon circumstances. A deranged person may express ideas regarding sin and future penalties that we unhesitatingly set down as pathologic delusions; but identical ideas are found in holy writ and presumably accepted by persons whose mental health is not under suspicion. Are these then *healthy* delusions?

In the latter part of his book the author presents a carefully detailed family, environmental, and personal history of Caro, reviews the list of psychiatric conditions that might be relevant and excludes them, and concludes that Caro simply lived and believed in accordance with Jewish tradition and the prevalent ideas of his time. From the psychological point of view the hallucination of Caro is well described when the Maggid said to him: "I am only the echo of your thoughts."

Printed in the book are comments by several psychiatrists with suggested diagnoses. Among them: hysterical dissociation, paranoid state, schizoid mechanisms, hypnagogic experience, personality dissociation, no evidence of schizophrenic illness. Which seems to suggest the futility of psychiatric terminology, especially of retrodiagnosis. As Wechsler remarks, the book "throws light on Hassidism, on that mystic side of Judaism, which bears considerable resemblance to Christian and other mysticism."

In this book Dr. Gordon has made a significant contribution to the understanding of personality development in relation to cultural history.

C. B. F.

THE BRITISH ENCYCLOPAEDIA OF MEDICAL PRACTICE: Medical Progress 1950. Edited by *Lord Horder.* (London: Butterworth & Co., 1950.)

This annual volume brings into a reasonable compass a review of new and old subjects in the light of considered opinion in the last 12 months. The editor has managed well to avoid the pitfalls common to many books of this type that attempt to present the greatest number possible of abstracts of papers on nearly every conceivable disease whether or not the work suggested in the papers has been thoroughly substantiated.

The first 152 pages contain *Critical Surveys* on the main divisions of medical science and are most readable, helpful, and accurate. The writers, and I pick Daniel Davies on Medicine and William Gunn on Acute Infectious Diseases as examples—the others are not inferior—have picked out the important considerations and conclusions that have been thought about and experimented with during the past years and that can now be logically and safely incorporated into one's own current sound knowledge. A selected bibliography is given at the end of each subject survey.

A few pages are given to new drugs and what actually can be expected of them. The rest of the volume—a matter of 350 pages or so—consists of abstracts of papers on subjects—from A to Z—each having a relevant bibliography. These abstracts are carefully done and form a good reference book in itself. In short, for workers in any field of the practice of medicine this book is good.

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